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Reader's Guide

April, and Easter are associated in most feminine minds with a change of apparel, new clothes, particularly hats, and all the trimmings of spring. Though the *Journal* has no such leanings, this issue marks the beginning of a new era in our existence. New printers have been engaged and several radical changes are herewith instituted. In the first place, how do you like our new type-face? Henceforth the editorial matter will be "monotyped" instead of the old, familiar, occasionally smudgy, linotype. The improved appearance will be accentuated by the shade of blue which has been selected as the regular cover colour for eleven issues each year. We think you will like the December green equally well. In addition to the cleaner, tidier *Journal*, one other important change goes into effect immediately, namely, hereafter we shall have a definite publication date—the **eighth** of each month. Not only will you readers be receiving a smarter looking copy but you will be getting it on time. This settled date puts an obligation on us to have all copy reach the printers earlier than heretofore. Would all *Canadian Nurse* conveners, both provincial and local, please note that there is a positive deadline of the **first of each month** preceding the month of publication. Any news notes or other contributions received after that date will have to be held over.

These changes have been made possible by the splendid support nurses all over Canada are giving their *Journal*. How do you like the new appearance? Tell your friends about it.

As guest editor this month, we welcome **Marjorie Jenkins,** honourary treasurer of the Canadian Nurses Association. A graduate of the Hospital for Sick Children, Toronto, Miss Jenkins has been intimately associated with schools of nursing during her whole professional career. As superintendent of nurses at the Children's Hospital in Halifax, she knows the problems which arise in the education of student nurses. Her strong appeal for a new approach to these problems is in line with the thinking and desires of the leaders in nursing everywhere.

Dr. S. R. Laycock has an uncanny knack of putting into the most expressive words, the ideals and aspirations of countless hospital personnel who are concerned not only with the technical training of the nurses but also with their personal development. There are not enough nurses willing and able to assume the responsibilities of leadership. The clearly marked road which Dr. Laycock points out for us should be an aid in developing the necessary maturity.

In keeping with our aim to bring authoritative information on new developments in medicine we are happy to present **Dr. Frederick Smith's** discussion of streptomycin. Dr. Smith is associate professor of bacteriology and immunology at McGill University.

Frances C. Harris, who is consultant in industrial nursing, in the Division of Industrial Hygiene of the Federal Department of National Health and Welfare, has observed the rise of industrial nursing during the past decade. She realizes more fully than most of us that the majority of nurses who have been so engaged had little special preparation for their work. Yet their contribution to the general well-being of the people is such that they have an important place to fill in the future. Every public health nurse, in particular, should read this challenging article.

Mother Albert, of the Hotel-Dieu in Bathurst, N.B., pictures the student nurse in her role of teacher of health. None of us uses all of the opportunities we are offered for health teaching. The student nurse, through her intimate contact with the patients in hospital, is in a strategic position to do more of it.

Mrs. Eileen Mayo won third place in our 1945 article competition. Mrs. Mayo has observed the various activities of Canadian nurses while employed by the Department of Health in North York Township, Ontario. **Mrs. Eloise Fleming** is head nurse on the eye ward at Royal Victoria Hospital, Montreal. **Erma R. Tait** is with the Tuberculosis Division of the Department of Public Health in Charlottetown, P.E.I. **Dorothy Smith** was working in the Colchester County Hospital, Truro, N.S., when she nursed the

(*Continued on page 274*)

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case of which she wrote. **Soeur Marie-Elide** is in charge of the operating-room at l'Hôtel-Dieu du Précieux Sang at Rivière du Loup, P.Q.

Every nurse has experienced the moment of ecstatic joy when for the first time her cap graces her head. To have the presentation of the caps become a formal ceremony adds something to the stirring experience. Our cover shows a student nurse who has just received her cap, lighting her candle as described for us by **Elinor M. Palliser,** director of the school of nursing of the Vancouver General Hospital.

Ce mois ci nous avons le plaisir de vous présenter une nouvelle réalisation: une page française. Les articles seront écrits par les infirmières canadiennes-françaises dans leur propre langue. Nous serons heureuses de recevoir, de la part des infirmières religieuses et laïques, des articles plutôt courts sur les différentes techniques employées au soin des malades et en faire le sujet de cette page spéciale. Mlle Suzanne Giroux a pris charge de cette page; les articles peuvent lui être envoyés à la chambre 504, édifice Medical Arts, Montréal 25, P.Q., ou au bureau de *The Canadian Nurse*. Avec votre concours faisons un succès de cette page!

Previews

How does the public health nursing supervisor determine the case-load which should be assigned to each member of her staff in a visiting nursing organization? Is it first come, first served, or is there a definite pattern which ensures the best use of available personnel? We asked **Kathleen McNamara** to describe the plan she follows in her district of the Victorian Order of Nurses.

Do you wish on the new moon? Are you a trifle jittery when there are thirteen people at a tea-party? Do you believe that onions are an excellent remedy for colds? Then you will enjoy the bubble-pricking which **Dr. D. E. H. Cleveland** has in store for you in his interesting discussion on "Folk-lore and Food" which is coming next month. And remember to get your fill of oysters this month because the next four months are minus the mystic letter!

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ANTISEPSIS

From Obstetrics to General Purposes

‘A general disinfectant must possess activity against the most important pathogenic organisms and, it is suggested, against at least these three: typhoid, staphylococcus and streptococcus. Moreover, any claim made should be required to be substantiated by a test designed to prove activity in the particular conditions made in the claim. Activity in the presence of blood, serum or other organic matter is very important, for so many are ineffective in these conditions.’☆

Among the original investigations of ‘Dettol’, not the least important was a study of its bactericidal potency against the haemolytic streptococci responsible for the great majority of puerperal infections and its capacity to form a durable barrier against these organisms. With respect to these qualities it proved far more dependable than any of the antiseptics with which it was compared; it eliminated the organisms completely in one-and-a-half minutes; on the treated skin it provided a protective covering which could prevent re-infection for five hours; its repeated application at full strength proved harmless; on the freshly scratched skin or the vaginal mucous membrane it caused neither pain nor other irritative effects. At Queen Charlotte's, London's great maternity hospital, the introduction of this antiseptic was followed by an over 50 per cent. decline in the incidence of haemolytic streptococcal infections.

Today ‘Dettol’ is preferred before all other substances not only in obstetrics, but in the operating theatre, casualty post, factory and home. For its remarkable bactericidal power is not specific to haemolytic streptococci, but extends to such common pathogenic organisms as *Staph. aureus*, *Bact. typhosum* and *Bact. coli*. Surgeons, physicians and obstetricians feel secure with an antiseptic which has been shown by repeated laboratory tests, confirmed by ten years' clinical experience, to be effective — even in the presence of blood, pus and wound contaminants — and at the same time non-toxic at full strength. And patients prefer it because its application, whether to wounds, abraded surfaces or mucous membranes, does not cause pain — and because it is a pleasant preparation which, unlike poisonous antiseptics, can be left in an accessible place for the use of the whole household.

☆ *Berry, H.* (1944) *Pharmaceutical Journal*, **3.**

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The special advantages in obstetrics

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'Dettol' Obstetric Cream is particularly suitable for application to the patient's vulva, thighs and hands. In preparation for obstetric operations the perineum, labia and vestibule should be swabbed with 'Dettol' Cream. It should always be smeared on the gloved hands before any vaginal or uterine manipulation, and during the course of a long delivery it should be used periodically for re-disinfection of the doctor's and nurse's gloves.

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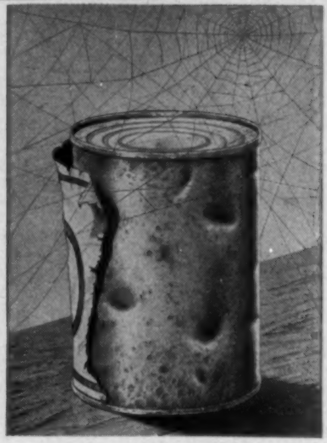

PERSONS afflicted with rabies were once suspected of barking like dogs and biting anyone around them. Killing the animal which bit the victim of this disease was believed to be an effective cure.

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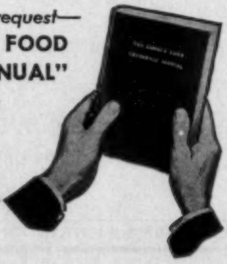

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Even *Junior Tampax* provides amply adequate protection—with its absorptive capacity of 20 cc. for *each tampon,* or 200 cc. for the period (10 tampons are usually considered an ordinary month's supply). In addition, *Regular Tampax* has a capacity of 30 cc., and *Super Tampax* 45 cc. for *each tampon* (or 300-450 cc. for the period).

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The results of this research parallel the experience of thousands of women who have found that Tampax affords thoroughly adequate protection

(1) Am. J. Obst. & Gyn., 35:839, 1938. (2) West. J. Surg., Obst. & Gyn., 51:150, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec., 155:316, 1942.

TAMPAX *accepted for advertising by the Journal of the American Medical Association*

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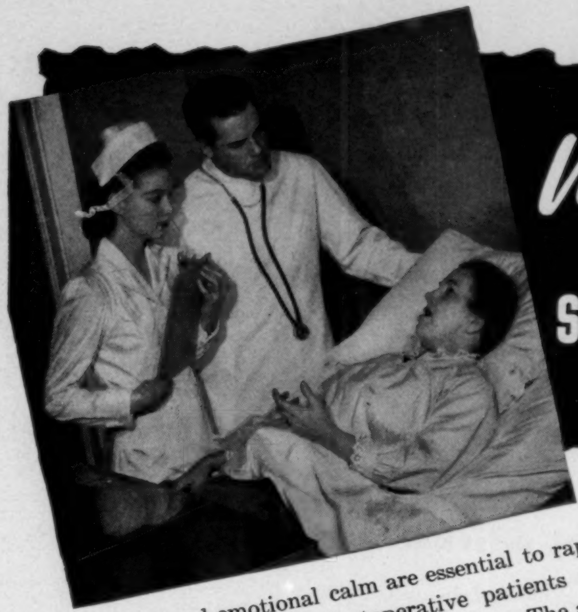

When PRURITUS SUPERVENES

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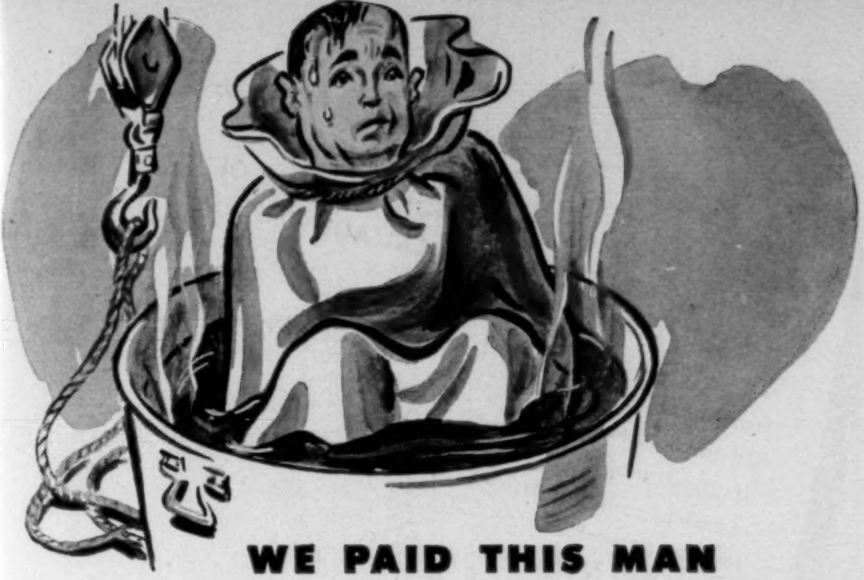

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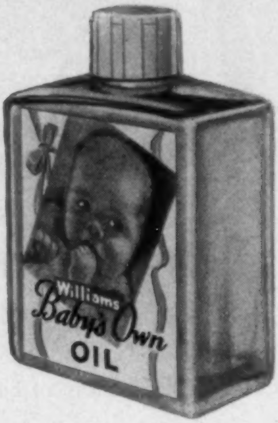

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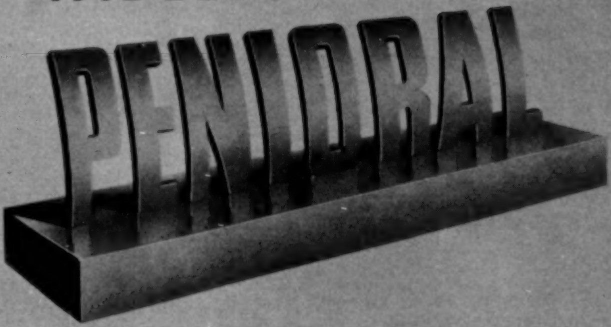

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The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-TWO NUMBER FOUR

APRIL, 1946

Apprenticeship or Education

WE HEAR A GREAT DEAL about youth these days — the part we need it to play in this moving epoch. Students of nursing are a large part of the youth of our country. Thirteen thousand are training in schools of nursing across Canada. What part do we wish *them* to play in this decisively important future, over which we are all so concerned today?

The ministry of nursing is broadening and widening rapidly, and even deepening. It is moving significantly into the realm of the mind and of the spirit. Science is claiming it now, urging a thorough and intelligent preparation for it. As nursing evolves, we will need to attract women of the finest calibre possible to it, women who will be worthy of its stewardship and destiny, who will be able to supply the leadership needed for the higher new levels of living to which the world aspires.

Human suffering can only be lessened by preventing it, and this means an understanding of all of its causes. We are coming to know more and more that the body and mind are one, inseparably linked together, the one affecting the other. One writer predicts that the healing work of the future will be the co-operative effort of many workers together—the doctor, the psychotherapist, the minister, and others. Whoever they be, the nurse will have to be the extended hand of all of them, in her position of closest intimacy with the patient. Refined and spiritually-minded, liberally educated, scientifically trained, this is the only type of womanhood that should be connected with the true work of nursing of the future.

How is this woman to be prepared, and who is to prepare her? This is one of our social problems of today. The hospital schools of nursing cannot hope to do so under their present systems, operating as they do on nineteenth century traditions in a twentieth century world. It is not possible for them to be effective in this larger and fuller way. As our century moves on, it is becoming more and more evident that our method of preparing young women for the nursing profession is both inappropriate and inadequate. What is the logic that denies the woman who chooses nursing for a career, the open and broad education granted the students of other professions? The noblest work for which a woman can offer herself has the narrowest of preparations. Closed in, restricted, and pressed down with physical requirements, the training impoverishes and stunts the growth of personality.

The hospital school of nursing seems to be the forgotten school in the field of education. Abiding under the shadow of the hospital, for the benefit of which it exists, it remains alone, unaided, outside the pale of public consideration. It proceeds largely untouched by modern educational enlightenment. Its growth and expansion are hindered by the character of its existence, being controlled by the hospital, whose main interest is its service to its patients. Financially dependent upon the hospital—for it has no budget of its own—it struggles along, crippled and unfree, deep in the mire of hopeless frustration.

This is no indictment against the boards of governors of the hospitals to which our nursing schools are attached. The office of these boards is one of trusteeship to us all—the public. Its responsibility is assumed by the finest of our citizens, voluntarily, without remuneration. Theirs is the task of keeping afloat the hospital that the sick may be cared for; and it is a most anxious task in these days of economic uncertainty. These trustees are forced to depend on their nursing schools as sources of security for attention to their patients. They are thankful that these schools are economic assets to the hospital, as we all know they are.

The problem is a financial one, inextricably tied up in the whole picture of our social economy. New methods of financing hospitals will have to be found soon or the hospital system of our country may fatally go to pieces.

The apprenticeship system in schools of nursing was acceptable in its day. It became rooted in our traditions when nursing was in its simple and elementary stage of development. Today, however, the picture is changed. Nursing is making rapid strides and has developed enormously within the last number of years, for it must keep pace with medicine. The studies and experience that are included in the preparation of the nurse of today are vastly different from those of fifty years ago. Social sciences, as well as medical sciences, must be widely studied. The nurse in her public health field must know all angles of social problems as well as health problems, and she must know how to deal effectively with people. In the hospital, she shoulders serious responsibilities, and must be versed in highly scientific techniques. In her private practice, more and more is being left to her judgment, for today she understands the causes of the symptoms she watches for, and the principles underlying their treatments.

This all means that nurses-in-training must be students as well as workers. The hospital, alas, depends on them largely for its services, and this is the root of our trouble. The obligations of the students to the hospital are continually at war with their obligations to their public, after graduation. More and more learning material is being poured into the minds of these students but little more time is being granted to allow their minds to absorb the mass of expanded material; and very little time is being left for their deeper needs as human beings.

What is there to assure us that young women are going to continue to enrol in our training schools? The competition of many openings for women now, with much more favourable doorways than the nursing profession can offer, may soon take a grave toll of available nursing service for Canada. Our national health schemes, and our hospital building schemes, will be rendered useless if there are not the nurses to man them.

A new way is needed that will give time for sounder methods of education and room for consideration of the things of the spirit. The student is first an individual, with a mind to be cultivated, a soul to be enriched, a personality to be developed and liberated generally. Professional knowledge and skill should be conceived as tools for a service demanding greatness in person and self-dedication.

The cause of healing and of health is being taken up vigorously by the nations of the earth as a step towards the bettering of mankind. Schools of nursing are part and parcel of this cause. Upon their character will depend to a large degree the character of the effort.

It behooves us, as a profession, to scrutinize our schools, to bring their weaknesses into the open, and to start to make some reforms. Nursing, if it is to play its part vitally, must be given a chance. It can only hope to be fruitful and to glorify itself through an exalted and nurtured womanhood.

MARJORIE JENKINS,
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Maturity—A Requirement for Leadership

S. R. LAYCOCK

THOSE WHO ARE CHARGED with the responsibility for the training or in-service education of nurses are always concerned with developing those who will give leadership to the nursing profession. For those in such authority the question is: "What qualities are necessary for leadership and how can we develop these qualities?" This article will attempt to answer, at least in part, the first section of this question.

In order to give leadership in her profession the nurse needs first of all to be really grown up. She needs to be mature emotionally, socially, intellectually, and morally.

EMOTIONAL MATURITY

Emotional maturity is of the highest importance for nurses. What does it mean to be mature emotionally? Probably the most important characteristic of emotional maturity is to be able to bear tension without blowing up—that is, to be able to handle the daily annoyances, irritations, and disappointments of life without recourse to having temper outbursts, dissolving into tears, pouting, sulking, feeling sorry for oneself, having one's feelings hurt, or going to bed with a sick headache. Children often exhibit these forms of behaviour. When an adult does so we say that she is "acting like a kid." Certainly, no adult who exhibits these infantile forms of behaviour, except in the major crises of life, is fit for leadership in the nursing profession. It is of the very nature of a nurse's job that she be involved in crises. The patient becomes worse or the illness takes an unusual turn; the patient is unreasonable; the doctor is arbitrary or demanding; the relatives make themselves a nuisance; there are too many demands at once; a fellow-nurse falls down on her job. To handle these or other unexpected events which are likely to turn up at any time, the nurse must be emotionally mature. She must be able to bear tension without blowing up.

SOCIAL MATURITY

To be socially mature a nurse must have several characteristics: (1) She must have achieved emotional independence from her family. (2) She must be able to make and keep friends among her age-mates. (3) She must have settled on a stable sexual pattern. (4) She must have accepted the ordinary amenities and courtesies as a necessary part of life. There is another important criterion for social maturity—to have found work that interests one—but it is assumed that the nurse has already achieved this in the choice of her profession.

No one is mature until she is psychologically weaned from her family. She has to leave home in her emotions. During her adolescence, she should come to think of her parents as dear friends and no longer as protectors and supervisors. Many parents keep their daughters tied to themselves emotionally so that these daughters never can get free. They remain "daddy's sweetheart" and find it impossible ever to fall in love with the opposite sex or to leave their parents for marriage. They are the ones who are homesick when away from home. They are the ones who continue to have crushes on their own sex. They never develop the stable pattern of falling in love with the opposite sex. They remain immature.

No nurse is mature unless she is able to have warm friendships with those of her own age. Being able to get along well with those who are older or younger is not a substitute. In the case of the unmarried nurse sound maturity involves not only having friends among age-mates of her own sex, but also being able to have good friends among married couples of her own age.

One sign of maturity is the acceptance of the ordinary courtesies and amenities as a necessary part of life. The person who is tactless or crude or inconsiderate of others is an immature person. Exhibiting courtesy to others at all times, having respect for their personalities, and showing considerateness are part of the price any individual must pay to be a real leader.

INTELLECTUAL MATURITY

To be grown up intellectually involves several characteristics: (1) To be able to make up one's own mind; (2) to be able to take responsibility for oneself and others; (3) to keep an open mind until all the evidence is in; (4) to be able to look one's own limitations as well as one's assets in the face; (5) to have come to a working compromise with life; (6) to be able to bear the indifference of the world to one's own fate.

The first characteristic of intellectual maturity is to be able to make up one's own mind. The little child is unable to do this. He is pulled this way and that by every wind of impulse that blows. He has to be helped to grow out of this. However, the object of any discipline worthy of the name is to help him to learn self-control and self-direction—not merely to keep him for the moment from injuring himself or being a nuisance to others. Too severe and too lax discipline both fail to teach self-control and self-direction. Discipline that is too severe means that parents and teachers exercise rigid control and the child gets no practice in managing himself or in making his own decisions. Then, too, very lax discipline is likely to leave the child at the mercy of every whim so that he doesn't get practice in making decisions. Coddling and overprotection, where the parents, out of mistaken kindness, shield a child from the hard decisions of life, also hinder growth in self-control and self-direction. A girl brought up in one of the types of homes just described will find it difficult to make up her mind. She will thus be incapacitated for leadership in nursing. In such a case she has to be helped by having practice in making decisions and in making up her own mind. Practice in this skill is as necessary as practice in the number combinations when one is weak in addition, subtraction, or multiplication.

A very important characteristic of being grown up is to be able to take responsibility for oneself and others. Many children who have been coddled or dominated are not able to take responsibility for themselves. When they grow up they expect their wives or husbands or employers to continue to look after them like children and to treat them as such. In the case of a man, his wife has to be a mother to him—buy his clothes, defer to his whims, and over-pity him when he has a pain. In the case of a girl, her husband has to treat her as a baby doll, wait on her hand and foot and generally spoil her. Obviously women who are unable to take reasonable responsibility for themselves have no place in the nursing profession—much less in leadership in it.

In addition to taking responsibility for one's self, maturity demands being able to take responsibility for others. There are many men who do not take responsibility for their wives and families. They may even desert them. Likewise there are women who do not feel an adequate sense of responsibility for their families. Neither of these pull their weight in the family boat. Then, too, there are in every community hosts of people who do little to promote the neighbourhood welfare. They do not pull their weight in the community boat. Such forms of immaturity are fatal to success in the nursing profession. In the very nature of a nurse's job it is vital that she be able to take responsibility for others. This is not merely a question of the ordinary duties of nursing service, important as these are. It is also a matter of taking emotional responsibility for patients. People who are ill are often cut off from their ordinary supply of emotional security. The good nurse, through a genuine interest in and concern for the patient, must "carry" patients emotionally. It is a very necessary part of the job of making sick persons well. Likewise, the supervisor must take something more than a professional responsibility for the work of those under her charge. She must take responsibility for their welfare as persons.

To be able to keep an open mind until all the evidence is in evinces a maturity few ever realize fully. It not only involves suspending judgment about those we come in contact with professionally and socially, but it involves an absence of prejudice—religious, racial, and social. Prejudice means just what it says—prejudging. It means deciding about other persons on the basis of their being of a particular race, religion, or social class—without knowing anything about them as individuals. When it comes to nursing, the good nurse is "objectively sympathetic" with respect to her patient, fellow nurses, and subordinates. She knows the French proverb—"C'est tout comprendre, c'est tout pardonner"—to understand all is to forgive all. This does not make her sentimental—that might be bad for those she wishes to help. It does, however, make her realize that the annoying characteristics of patients and colleagues grow out of their past experiences in childhood and their present problems. As a result she takes intelligent measures either to help them or to deal with them in as wise a manner as possible. Nurses should have as their motto: "I will never allow myself to dislike a patient or a colleague or a subordinate." This is not merely idealism. It is common sense and self-interest. Those whom we dislike are almost certain to dislike us—and to be a nuisance to us. On the other hand, few people can withstand being liked. It is well to remember, too, that "We cannot elevate those whom we despise." The psychological interpretation of the scripture verse—"Without shedding of blood there is no remission"—is true. The price of helping others is a genuine interest in them and the giving of our own personality and energy and skill in serving them. Suspending judgment regarding their difficulties until we have all the facts will enable us best to help them.

Another characteristic of the mature person is to be able to look one's own limitations in the face and to accept and deal with them without being too upset by them. Marked sensitiveness to criticism is not merely a symptom of inferiority. It is a symptom of immaturity. The mature person knows she has limitations—physical, mental, and social. She knows she is no world-beater. On the other hand she is aware that she has assets which can be useful in serving others. She should remember a bit of homely philosophy that limitations and assets lie very close together. Often a liability can be turned into an asset by intelligent handling—as witness the late President Roosevelt's lameness. On the other hand, an asset may be turned into a liability—many men as well as women have had their careers wrecked by a pretty face. Even with the handicapped it very often isn't the handicap that holds them back but how they *feel* about their handicap. The old motto of Socrates, "Know Thyself", is a good one. Perhaps it would be best to enlarge it into Dr. Hadfield's dictum—"Know Thyself, Accept Thyself, Be Thyself." Wallin gives as his first criterion for mental health the following: "The well-adjusted person has a reasonable insight into his own personality make-up and his own problems of adjustment." The mature nurse is, therefore, aware of her own shortcomings and makes intelligent adjustments to them.

Another sign of maturity is that of having come to a working compromise with life—its joys and sorrows, the fact of death, success and failure, kindness and enmity, the fickleness of friends and the jealousy of enemies. To be able to "see life steadily and see it whole" is the mark of the mature person. The person who acts like a Pollyanna and refuses to see any of the disagreeable things of life is equally as immature as the cynic who sees nothing but life's limitations and disappointments. The mature person has some sort of philosophy which gives meaning and purpose to life. Many people find this philosophy through their religion, but everybody has to come to a working agreement with life. An old definition of mental health was "the intelligent facing of reality." To be able to face all life's difficulties and yet have faith in mankind and its possibilities is a sign of maturity.

Still another sign of being grown up is for the nurse to be able to face the fact that she is not all-important—that the world does not revolve around herself. The adolescent girl hasn't reached this stage. She wants to impress everyone with her importance. The mature person is willing to recognize that the world would go on if she dropped out tomorrow. On the other hand she realizes that she has a worthwhile contribution to make, then goes ahead and makes it.

Moral Maturity

There is just one requirement for moral maturity—that is to be able to treat every other individual as if he were of infinite worth. This fundamental respect for personality is the most important aspect of Christian teaching. Flowing from it have come all the worthwhile accomplishments of our western civilization—the freeing of the slaves, the enfranchisement of the common man, the raising of the status of women, the abolition of child labour, the improvement of conditions for the insane and the criminal, the establishment of child and family welfare services and provision for old age pensions, mothers' allowances, family allowances, etc.

The idea of moral maturity is also expressed by Kant's dictum: "Never treat people as *means:* always treat them as *ends.*" In other words, the morally mature person treats others in a way which is for the latter's best good—never as merely a tool for her own satisfactions.

No one ever completely reaches the goal of moral maturity. However, it is important that nurses, in their professional relations with patients, superiors, and subordinates, approximate to doing so. Only so can they make their major contribution in their profession. To the degree to which they do so will they be worthy of posts of leadership.

Increasing Maturity

The other question which those in charge of the development of student or graduate nurses will ask is how nurses can be helped to attain maturity. The most obvious answer is that prospective nurses should choose parents who are themselves mature and who will guide their daughters towards emotional, social, intellectual, and moral maturity. However, given some reasonable degree of maturity to start with, some part of the training for maturity can still be done at the student or even the graduate level. The first step in such a program is for the instructors and other leaders to have clearly in mind the kinds of maturity towards which they hope to develop the student or graduate nurse. Secondly, they must see to it that nurses get practice in being mature with plenty of encouragement and praise for making progress. Then, too, courses in mental hygiene will help both graduate and student nurses to understand why they act as they do and how their particular personality patterns came to be formed. Counselling services to help nurses to understand themselves and to iron out their difficulties should be available at both the training school and the graduate level. While no one by taking thought can add a cubit to her physical stature it is possible, by careful study and adequate counselling, to add at least part of a cubit to her psychological stature. Professional growth for nurses should mean more than an increased knowledge of techniques and administrative practices. It should include helping the nurse to become a more mature person—for on her degree of maturity will her professional success, in no small measure, depend.

Streptomycin and Related Phenomena

FREDERICK SMITH, M.A., M.B., B.CH., M.R.C.S., L.R.C.P.

THIS ARTICLE SEEKS, as its primary object, to give some account of what is known of streptomycin, the latest of the antibiotic substances to be introduced into medicine. It seems to the writer that a proper appreciation of what to expect from this new drug will be facilitated if it is viewed against the background of past achievements in controlling infection. The phenomenal success of penicillin has precipitated extensive search for substances of similar origin, and frequent additions to our therapeutic armament may be expected. Each new drug will carry with it the hopes and aspirations of its discoverer, and will be announced with corresponding enthusiasm, to be followed inevitably by a more accurate and sober appraisal. Of the numerous anti-bacterial agents of this nature already described, only three have found a place in therapeutics, and these are penicillin, streptomycin, and gramicidin.

Chemotherapy, in this sense of magic bullets for specific infections, is an ancient study. Before the existence and habits of microbes afforded an understanding of infectious disease, the nightmare of epidemics was infinitely worse than it is today, and it is small wonder that throughout the ages man has sought in nature for anti-infection drugs. Some of those still in use today have their origin in antiquity: male-fern was known to Threophrastus (570 B.C.) and to Galen; the influence of mercury on syphilis was discovered about 1500 A.D.; cinchona bark was recognized in the seventeenth century by the Indians of Peru as a cure for malaria; and ipecacuanha was used by the natives of Brazil for dysentery at about the same time. Despite the occasional invaluable discovery, however, the great mass of bacterial and virus diseases remained essentially unaltered by the search for specific remedies. Admittedly, an ever-increasing list of chemicals we may call antiseptics was compiled, and these would all kill bacteria. They differ sharply, however, from the substances called antibiotics in that all of them are too toxic to the body to be introduced in concentration sufficient to kill the germs of disease, and antiseptics have, therefore, played an insignificant part in the treatment (as distinct from prevention) of infection. Indeed, during the sixty fruitful years since the first microbic causes of disease were established, drugs have played little or no part in the treatment of infection, until the introduction of the first sulphonamide in 1936. Throughout this period, bacteriologists became increasingly impressed by the ability of those who had convalesced from an infection to withstand a second attack of the same disease. An explanation of this immunity was sought, and often found, in the body fluids and cells of the individual, and a whole new science of immunology was developed. The practical results in terms of therapeutics were to be seen in the ever-increasing lists of antiserums, vaccines and toxoids, for the cure and prevention of disease. Sometimes the antiserums were purified globulins from the blood serum of a hyperimmunized horse, sometimes from a rabbit, and occasionally from a human convalescent from the disease in question. In principle, however, the concept of recovery from infection involved the transformation of a susceptible human into one comparable with the immune convalescent, through the injection into his body of the serum fractions which determined recovery. Such efforts were sometimes attended by dramatic success, as with the use of diphtheria antitoxin and antipneumococcus serum.

In spite of all these studies and explanations of the phenomena of immunity, however, there remained a tragically long list of infections for which little or nothing could be done. It is easy to understand how the medical world was galvanized into renewed chemotherapeutic activity by Domagh's account, published in 1935, of a water-insoluble basic azo dye, known as prontosil, and its ability to protect mice from fatal doses of streptococci. It was soon shown that prontosil is changed in the body into sulphanilamide, and a new era dawned in the treatment of infection. These sulpha drugs were heralded as being entirely non-toxic, a statement which has been very radically modified. The early enthusiasm for all that the sulpha drugs were to accomplish has become a bit tarnished, but one adverse result of their introduction is still with us. All interest in the aforementioned immunity phenomena, and the serums which were their practical sequel, were discarded almost overnight, regardless of whether a given serum was valuable or not. At the present time it is often impossible to obtain type-specific antipneumococcus serum, on those occasions where its use is imperative, because commercial production was largely abandoned when sulphonamides were introduced. However, a fair appraisal of the status of sulphonamides at the present time would re-affirm their great effectiveness in combatting certain varieties of infection, with a reminder that time had revealed certain definite limitations. These are chiefly toxic manifestations, neutralization by pus, a tendency for the microbes under attack to develop resistance to the drug, and their failure to influence many infections. These properties, common to all sulphonamides in varying degree, served to whet the appetite for new and better therapeutic agents.

Penicillin appeared to answer one requirement insofar as, by contrast with sulphonamides, it was stated to be non-toxic to the human. In relative terms this is so, although of late a few minor evidences of individual idiosyncrasy have revealed themselves. There is, furthermore, much less evidence of acquired microbic tolerance to penicillin than is the case with the sulpha drugs. Penicillin, however, acts on much the same range of bacteria as do the sulphonamides, and the residue of untreatable diseases remained essentially undiminished.

Thus was the stage set for the introduction of streptomycin, not as a substitute for a previous remedy, but as an entirely new member of the cast. It was discovered in 1944 by Waksman in cultures of *Streptomyces griseus*, a soil organism belonging to the *Actinomycetes*, which are similar to the moulds and fungi. The production and purification of streptomycin present many difficulties, and the yield, so far, is insufficient to meet the growing demand for it. For that reason it is not generally available for use at the present time.

Streptomycin is a nitrogenous organic base, usually supplied as the hydrochloride. The crude, brownish powder contains considerable impurity, as is the case with commercial penicillin, but both substances may be crystallized, and the pure white powder gives a colourless solution. Streptomycin is much more stable than penicillin, in both powder and solution, but should be stored in the ice-box nevertheless. In general, streptomycin is administered by the same routes as penicillin—intravenous, intramuscular, or intrathecal, and is largely excreted unchanged in the urine. Streptomycin may also be applied locally in wounds, but one major point of contrast with penicillin is its failure to be absorbed from the alimentary canal.

The great value of streptomycin lies in its dramatic effect on microbes not influenced by penicillin or sulphonamides. Most important of these, because of their frequency, are the gram-negative rods of the *B. coli*, typhoid, dysentery series. Streptomycin is superlatively good in infection of the urinary tract with *B. coli*, and provides the first really adequate therapy of this condition. This is, in part, dependent on the fact that streptomycin is enormously concentrated in the process of excretion by the kidney. Precisely how valuable the drug is in the treatment of typhoid fever and bacillary dysentery remains to be evaluated. The same applies to such infections as *B. Friedlander*, pneumonia, and a number of cures are already reported.

Of all infections for which there has hitherto been no specific remedy, none exercises the public mind more than tuberculosis, and a number of reports suggest the value of streptomycin in this disease. At the present time, the evidence is strong that experimental tuberculosis in the guinea pig can be cured with streptomycin, and there have been encouraging signs that the human disease may be favourably influenced. These investigations must of necessity be continued for some time, however, before the exact place of streptomycin in the treatment of tuberculosis is established.

A number of other infections, such as tularemia, undulant fever, and wound infections with *Pseudomonas pyocyanea* and *Proteus vulgaris*, also respond well to streptomycin. One very satisfactory application of it is in the treatment of sinus infection with *Hemophilus influenzae*, on which penicillin has no effect.

In all instances, it must be remembered that these antibiotic substances must gain access to the environment in which the bacteria live before they can exert any effect. Such effect is determined by the concentration of the drug and the time during which it acts. We see, therefore, the need for considerable ingenuity in introducing it directly into sinuses and abscess cavities, and for determining the nature of the microbe concerned and its tolerance of the drug.

Finally, it might be pointed out that for two great groups of infectious agents—viruses, and moulds and fungi—no specific antibacterial substances have yet been isolated. There is still much room for research.

It is good practice always to use light colors when painting a room where the lighting is not good. A room inclined to be glaring with sunlight can be made more liveable by the use of somewhat darker paint colors.—*News Bulletin.*

What have Canadian Nurses to Offer Industry?

FRANCES C. HARRIS

DURING TIME OF PEACE the duties and functions of the Federal Department of Health, insofar as they were concerned with health of persons engaged in industry, consisted mainly in co-operation with provincial, territorial, and other health authorities. In time of war these duties and functions became greatly extended by reason of an undertaking requiring contractors with the Government of the Dominion of Canada to provide medical supervision for workers engaged in war industry.

The Division of Industrial Hygiene of the Federal Government made extensive surveys of war plants for the purpose of establishing medical, nursing, and preventive services to the satisfaction of the Minister. The objective of this industrial medical service may be briefly stated as the maintenance of maximum health and efficiency of all workers, this objective to be obtained, as far as possible, by the application of approved methods of disease prevention and health promotion. The basic personnel required consists of qualified physicians and nurses.

Shipyards, aircraft, and munition plants, factories manufacturing or producing supplies for war purposes, have co-operated with the Federal Department of National Health and Welfare in the promotion of the preservation of the health of workers engaged in war industry. Frequent inspections have given the Division of Industrial Hygiene a fairly comprehensive picture of the industrial nursing situation throughout Canada. Now that we have entered the transition from wartime to peacetime industry, many industries are retaining the medical and nursing services.

Government inspection of nursing service has brought to light certain problems of the industrial nurse. In the foreground are the questions: *Are we sure we know what service industry expects from nurses and does industry know what we have to offer?* Industry means people at work. Industry is run for profit. Industry can never be run for the sole purpose of occupational therapy.

The duties of an industrial nurse may confine her to the plant itself, or it may be necessary for her (because of lack of parallel public health facilities) to do community work. It is appreciated that duplication of work must be avoided, but it is also a fact that industry has a special interest in the care given to employees and their families. Industry pays the cost of sickness and absenteeism.

It is not the purpose of this article to state how far industry should go in the establishment of health programs for employees. There can be no doubt that the compensation laws were and still are one of the basic reasons for the rapid improvement of industrial health. It is not at all unusual for a labour group to insist upon improved medical and nursing service. In many Canadian centres not only plant workers but the families of plant workers depend entirely on the "company nurse" for service.

The program developed by the plant manager, the industrial physician, and the industrial nurse may fall short of the ideal. The qualifications of personnel are not always a matter of grave concern. There is food for thought in the realization that after all these years there is little difference in the minds of many people regarding the public health nurse, the hospital nurse, and the private duty nurse, but one thing is certain—until public health teachers, medical officers, and research men co-ordinate their efforts to educate the public to preserve its own health, industry will likely make its own evaluation of the needs of its workers.

The function of the industrial nurse is to keep as many people at work as possible; this is what industry expects from nurses.

Now, what have nurses to offer industry? If nurses are concerned with the promotion and preservation of the health of Canadian workers it follows that Canadian workers must be provided with qualified nurses. Who is to evaluate the qualifications of such nurses? Usually, discriminating selection of the nurse for the position has been the responsibility of management. Nurses have entered industry without a clear idea of its requirements or of the scope it affords. It speaks well for the adaptability of nurses that so many have made a real success of their duties in this field. To these pioneers we are sincerely grateful. Much of the information they have passed on to us was acquired by hard, untiring work, good thinking, and good judgment.

When nursing service is carried on in non-medical organizations it is, to a large extent, controlled by private enterprise. However, as many of the industrial nurse's duties are directly influenced by community health problems it is important for her to cooperate with the community health program. It is equally important for nurses employed in public health fields outside of industry to have an appreciation of the work of the industrial nurse. A survey of the Canadian field reveals that directors of public health nursing throughout this country are now making an effort to include industrial nurses in the general public health program.

The lack of uniform standards of training for nurses in industry and the lack of guidance and professional leadership have, in the past, created an isolated group. Are directors of nursing education frequently called upon by industrial nurses for help? If not, why not? Is it because industrial nurses are unaware that help is needed or do they not approve of the type of help offered?

Not many Canadian nurses in industry have had public health training. It must be admitted that the generalized public health course, as it has been offered in Canada and in the United States for the past few years, has not provided many opportunities for field work in industrial nursing. Even at present this is a problem. Many who stress the importance of field work in other branches of public health nursing feel that academically qualified instructors without sufficient field experience are not adequately prepared to guide industrial nurses. Unfortunately, many nurses who have made a success of industrial nursing are not qualified to teach.

Industrial nurses recognize the need for an ethical code and Standing Orders through which they can work with the medical profession. Here, as well as elsewhere, the medical and nursing professions are complementary to each other. Insofar as therapeutic assistance goes, the industrial nurse functions in essentially the same manner as in the hospital or on a private case. There is one important and unfortunate difference; whereas the private duty or hospital nurse works under the close and specific guidance of physicians, plant nurses often have to get along in the absence of physicians. It is an illegal and unethical arrangement for nurses to work without specific instructions, i.e., Standing Orders or general methods of procedure which bear the endorsement of the plant physician. But it is important for institutional nurses to remember that written Standing Orders cannot meet every situation likely to arise in industry. It is occasionally necessary for nurses in industry to depart from some hitherto accepted tradition or practice. Every day in her factory department the industrial nurse has to make decisions on the evidence before her as to whether the cases she sees are ones with which she is qualified to deal, or whether they must be referred for medical advice. In England, they call it "provisional diagnosis." American industrial nurses have laughingly called it "good guessing." In Canada, nurses usually call it "using their good judgment."

One of the chief underlying reasons, often unexpressed, for appointing trained nurses to industrial posts is that the trained nurse realizes how much she does not know and the true line of demarcation between her sphere and the doctor's, whereas the less well-trained personnel makes their most grievous mistakes at just that point. With the expansion of the Federal and Provincial Divisions of Industrial Hygiene it is hoped that in the future the large number of industrial nurses working alone will find that medical advice will be available to them. In the meantime many Canadian nurses engaged in industry are being guided by the Standing Orders prepared by the Council on Industrial Health of the American Medical Association.

In the United States industrial nurses have formed their own organization. There has been thought along this line in Canada but in many sections industrial nurses are co-operating very closely with established public health groups with mutual success. One cannot be dogmatic and, of course, the development of any plan of organization depends in a large measure upon the industrial nurses themselves. So far, in Canada, the trend throughout the provinces has been to encourage industrial nurses to attend general public health meetings, to take advantage of the short courses and institutes which our universities are now offering and, if possible, to bring the industrial group into the public health nursing group rather than form a separate organization.

Much of the service which has been developed in the larger industries has been made possible through the splendid co-operation of the part-time plant physician who has given guidance and counsel to the nursing staff. The development of nursing service in the smaller industries has taken place because of the need for such service. The majority of these nurses have been employed through a non-medical personnel management. There is definite need of establishing the proper liaison between the medical profession and the nurses now engaged in small industries with little medical supervision. In the past little practical help has been given to these nurses by the Federal or Provincial Departments of Health. Recently a consultant in industrial nursing was appointed in the Province of Ontario. For a short period Manitoba industrial nurses were provided with a consultant in industrial nursing. During the last year of the war many plants were visited by a consultant in industrial nursing from the Federal Division of Industrial Hygiene.

The federal consultant in industrial nursing has had three main objectives:

1. To advise nurses in industry to arrange to work under written Standing Orders signed by a physician. He may be on call at the plant only in cases of emergency but no nurse should work without some direct contact with a member of the medical profession. This is basic.

2. It has been her purpose to meet directors of nursing education and directors of public health nursing in order to formulate plans whereby nurses in industry throughout Canada may be given the opportunity to attend lectures bearing directly on industrial nursing and public health principles. It has also been the policy of the consultant nurse to stimulate the interest of industrial nurses in those courses which are offered and to interpret to management the necessity for them.

3. Because Canadian public health nurses need to know something of the industrial nursing set-up and field, and many industrial nurses need more public health training, many leaders in the nursing profession deem it advisable that industrial nurses should be included in the general public health group rather than form a separate organization as has been done in the United States.

The third objective of the federal consultant nurse has been to promote co-operation between industrial nurses and various other public health groups.

Much has been said in nursing circles regarding the lack of leadership in industrial nursing. Industrial nurses have been criticized for vaguely expressed opinions. It is believed things ought to be changed. The dissatisfaction of Canadian nurses has, however, been negative rather than positive. They know definitely what they do not want, but do they know what they do want? This is not a situation where a reformer is needed with a single idea of what ought to be done. The traditions and precepts of industrial nursing are still being built up. They are not merely the reflections of prevailing customs in other spheres of nursing. At a time when rapid developments are taking place it is difficult to keep up-to-date. The responsibility of industrial health rests not alone with the industrial nurse but with labour, organized medicine, hospital and nurse associations, as well as public and private health agencies. What is needed is an analysis of the present problems of Canadian industrial nursing. In what way can they be separated from the problems of other groups of nurses? It is seldom possible to proceed with the real work of construction until existing opinions and customs have been examined. Industrial nurses seeking help ask for contact with nurses doing similar work and having similar problems. It is necessary for them to share their experience, not only with industrial nurses, but with nurses in other fields of public health.

In the larger centres nurses do meet frequently and are of great help to each other. The contribution which has been made to the industrial field by the nurses of Montreal is recognized throughout Canada. The medical directors and nurses of the great shipyards of Vancouver and Pictou have contributed invaluable service to other nurses in the provinces of British Columbia and Nova Scotia. A history of industrial nursing is now being compiled in the Division of Industrial Hygiene of the Province of Ontario. Nurses all over Canada are eagerly awaiting this publication. We need a literature, which experienced industrial nurses could supply, devoted to giving information of what has already been done in industry.

Industrial nurses in Edmonton, Calgary, Saskatoon, Regina, and Winnipeg are justly proud of their achievements in garment factories, packing houses, biscuit factories, iron foundries, etc. The name "Hudson Bay", so significant in Canadian history, is also outstanding in the contribution to industrial health made by departmental stores of Canada.

In the East, industrial nurses of Halifax, Truro, Pictou, New Glasgow, Amherst, Dalhousie, Saint John, St. Stephen, and Moncton have developed services in shipyards, paper mills, lumber mills, garment, candy, brush and broom factories. To highly industrialized Quebec and Ontario these nurses turn for guidance, but the nurse working in a city surrounded by social services, hospitals and doctors has little conception of the duties and problems of a nurse working in a small New Brunswick town or an isolated plant in Nova Scotia.

The Canadian Nurses Association recently passed a resolution that an effort be made in all provinces to organize industrial nurses within the public health group. Latterly there has been a swing in Canada towards the generalized field of public health nursing but it should be remembered that in many Canadian centres public health services are specialized and many public health nurses have little experience in the generalized field. It is a professional obligation for industrial nurses to gain health knowledge and skills, in order that they may fulfil the function of health teaching. This teaching function presupposes professional preparation which either includes public health nursing in the basic course in nursing, or adds it to the basic course. Even though industrial nurses find it impractical, under present circumstances, to enlist for the university certificate course in public health it is possible to attend institutes and refresher courses which are put on from time to time. Industrial nurses should maintain membership in their local, provincial, and national nursing organizations, not only to keep their own professional standards high but to contribute to the sound development of nursing. Leaders in nursing education will then be in a better position to appraise the needs in special training for industrial nurses.

In the meantime, *What have we to offer industry?* It is reasonable to assume that the qualifications which are essential to the success of any nurse are also essential to the nurse who is to serve industry. Over and above professional qualifications, personal qualifications must be considered—good physical and mental health, initiative, interest, good judgment, ability to work with people, and a pleasing personality are essentials in industrial nursing. The nurse in a small industry or in an isolated community must be able to organize her work and learn on the job. If a nurse offers industry these qualifications, with a well-developed nursing background, industry offers her an unlimited field.

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The Student Nurse as a Health Teacher

MOTHER ALBERT, R.H., B.SC.N.

IT IS UNFORTUNATE that we must so often wait for times of national and international disturbance to institute social reforms and improvements, while in times of peace and plenty we tend to idle along, oblivious to the great waste of opportunity. However, that seems to be our way.

The program of health education, as we know it today, is generally considered to be an outgrowth of the first World War. It has been successful in some lines of endeavour, but unsuccessful in others. Evidence of this failure was brought to the fore, during the recent war, by the findings of the local draft boards for army recruits, where defects such as poor vision, decayed teeth, and enlarged tonsils were among the most numerous physical defects to be noted. Such findings are a severe indictment against a nation, because they could have been corrected or prevented by a well-planned health education program.

To be successful, a program of health education must be planned to reach all the members of the community, of all ages, occupations, races, and religion. Because nurses are associated with all the groups that form a community, they occupy a key position in the educational process. No other group of workers has so great an opportunity to influence the living habits of the people. While it is usually the public health nurse who is associated with the health education program, the hospital nurse is also an important cog in health machinery being in a very strategic position to offer a large and important contribution to the program.

PREPARATION OF THE NURSE AS A HEALTH TEACHER

How to prepare the nurse to be a health teacher and how to improve her teaching methods is a question confronting the nursing profession today. It is one thing to recognize the nurse as the logical one to teach health, but it is a far different thing to make her a good teacher. Directors of nursing schools should keep in mind and convey to their students the idea that actual community needs and post-war health problems make it imperative that public health services and hospitals become more closely integrated. It is time to recognize that the personnel of a public health department and the personnel of a hospital are in the same line of business—maintaining the health of the community—and that they will do better if they work together. Once the student nurse is impressed with this idea that her role as a hospital nurse gives her unlimited opportunities to promote health education, and classes her as a real health worker, she will then be in the receptive frame of mind desirable for further directives along this line.

As to ways of bringing together the health nurse and the hospital nurse—one way would be to have one of the public health nurses in the vicinity of the hospital on the nursing school faculty. Arrangements could also be made whereby the student nurse would be given a month or two of public health nursing under the supervision of a public health nurse. Thus, operating together in and from a health centre, these two branches, the public health services and the hospital, which are inter-dependent for effective service, will have a fair opportunity to learn how to work together. Furthermore, the student nurse will receive a very practical and effective preparation for her work as a bed-side health teacher.

TEACHING METHODS

Now the question comes up: How can a nurse incorporate the teaching of health into her daily routine nursing care of her patients? Her first and very effective teaching will be what I will call *unconscious teaching*. Nurses are constantly being observed, and what they do or do not do has a profound influence upon those with whom they come in contact. The appearance of the nurse, her grooming, posture, the condition of her skin and teeth are all noticed and observed by patients and friends. These observations tend to influence their behaviour and attitude far more than the nurse may realize. Therefore, the nurse should strive to improve this form of teaching by giving careful and constant attention to her appearance, maintaining good posture, eating a balanced diet, taking regular exercise and plenty of rest.

The more conscious kind of teaching is what one generally thinks of when one speaks of teaching. In the hospital field, the nurse has a unique opportunity to develop an individual method of teaching, *a nurse to patient method*, which seems to be lacking in our present health program. We safeguard communities and provide healthful environments but, in spite of this, individuals, as such, will still neglect their personal health. And everyone knows that if we would have a healthy and prosperous community, we must have a healthy and happy individual.

How is this individual teaching to be approached and are there known rules and principles to guide the student? One of the first principles, based on good common sense, is that the lesson taught should correspond with something that is being done for the patient. Take, for example, when the nurse is giving the patient her toothbrush and supplies for cleaning her teeth. If it is evident that the patient is not accustomed to this hygienic measure, then is the time to show her how to do it properly and tell her *why* it is so important. When the nurse presents water or a wet towel to the patient to wash her hands before meals, why not tell the patient of the possible presence of germs on her hands, some of which may be harmful if they enter the digestive tract, especially at this moment when her vitality is lowered. The nurse on a contagious case, as she washes her hands and dons her gown and mask, has a splendid opportunity to talk about cleanliness and about the danger of spreading disease. A resourceful nurse can find opportunities to teach her patients in almost any treatment or nursing care she gives them, and her teaching will be effective precisely because the patient does not realize that she is being taught and is not offended by the nurse's suggestions, as she probably would be if the remarks were too detached and offhand.

Another very good principle is *to listen* to patients. They are usually only too glad to speak about their illness, their homes, their worries. The nurse may help by putting in a few questions to keep the patient on the subject. In this very matter of fact way, she will learn how her patient reacts to her illness, and upon this knowledge base plans for future teaching.

The importance of having the patient watch how the nurse herself does some particular thing, then allowing *the patient to do the procedure herself*, hardly needs to be emphasized. This type of teaching may be utilized chiefly in the maternity department, in showing the young mother how to bathe the baby, to put the diaper on, to care for the nipples, to prepare formulae, etc.

Most nurses feel more at ease if their hands are busy doing something, and consequently find it easier to talk as they work. For this reason, the oftener the nurse can give some service as she teaches, the better quality there will be to her teaching. In giving nursing care, much time is lost in useless chatter or in long silences. While giving a bath, making a bed or some such routine practice, why not use that time for good teaching? This is a time when a patient is being made comfortable and when she feels relaxed and willing to talk and to be talked to.

Another factor that makes for successful teaching is the *quality* of the material that is presented. The nurse must first ascertain that her information is true, then present it in a way acceptable to the patient. Because most people dislike being told not to do this or that, a positive approach is better than a negative one. More people react willingly when asked to do certain things and when given a logical reason for doing them, than they do when given an injunction not to do a certain thing.

All authorities in teaching health emphasize the importance of *using simple language*. Our aim is to give information, not to display our own knowledge, so we must choose words suitable to convey the information we wish to impart. The nurse should strive, in her teaching, to adjust her choice of words to the level best suited to each patient. This requires a knowledge of the vocabulary used by various groups, but this knowledge the nurse can acquire by listening to her patients and noting their expressions.

Another good principle is to *teach only what the patient can absorb* at one time. It is much better to select one topic and develop that, choosing the one most needed in a particular situation. For the ill-nourished patient, the most pressing need would be instructions on well-balanced and nourishing diets; for another who seems to be on war terms with soap and water, there is no doubt that a persuasive talk on personal hygiene would be very salutary and a very helpful kind of teaching; good sound advice on the proper way to relax and rest, both physically and mentally, would certainly not be lost on a patient under a strain from worry and overwork. And thus, the nurse, by conforming her teaching to the needs of her patients, will make her instructions attractive and helpful.

Another device useful in bedside teaching is *the use of paper and pencil*. It becomes necessary in planning schedules for rest, exercise, feedings, diets, etc. It may be of use also in explaining to a patient an operating procedure or a treatment about which a patient is somewhat confused or frightened. Sometimes in giving an explanation, our choice of words is such that the patient receives a far different idea than we intended to convey. By combining our verbal instructions with a diagram, we may thus clarify and strengthen our teaching.

APPLYING THE PRINCIPLES

Now that the general principles that should guide the nurse in health teaching have been discussed, suppose we apply a few of these principles to a particular case. For instance, let us consider a patient suffering from pulmonary tuberculosis, one of the great health problems of today. As a rule, those with tuberculosis are only transient patients in a general hospital. After diagnosis is made, they are removed to a sanatorium, if admission can be obtained, or returned to their homes. If the patient is admitted to a sanatorium, she will receive there all the instructions she needs for her own protection and that of her environment. Let us suppose that the patient returns to her own home. Then the duties of the nurse as a teacher are manifold.

One of the first things the patient should be taught is *to react properly to her illness*. More and more the importance of mental relaxation is being recognized and it is a fact that the ultimate recovery of the tubercular patient depends almost as much upon the adjustment of financial and social problems as upon the medical and nursing care which she receives. The first thing then that the nurse should do is to know her patient and find out, chiefly by listening and very discreet questioning, what are her mental and emotional reactions to illness. Then only can the nurse be of real help in assisting her to correct her attitudes and adjust her reactions.

The patient, having been helped to the right mental attitude, must be taught the principles of personal hygiene, especially in connection with her disease. She may already know the value of good care of the mouth and teeth, but she may not know that, owing to the nature of her disease, her saliva may be contaminated and, therefore, the water used in rinsing the mouth and other cleansing material must be received in a special basin, destined for her use only, and this waste discarded so as not to be a menace to the others. She should be taught the value of cleanliness, the beneficial and resting effects of a good bath, of alcohol rubs, etc.

Particular stress should be given to the important factors of rest, food, and fresh air. The patient should be taught to look upon the diseased lung as upon any open wound. If one has an open wound on a hand and keeps pulling off the bandage and breaking open the new tissues, there is a chance that the wound would never heal. The same applies to the lung. The rest in bed is to the lung as the bandage is to the wound. That is why rest should be taken with a knowledge of the reason for taking it. That is why, also, patients are instructed not to put their arms over their heads when resting, to avoid stretching their arms to reach things on their bed-side table or stooping from their beds to gather things from the floor; to speak and laugh moderately; to stop all coughing if possible and to omit all movements that will open or disturb the wound in the lung. Patients on the rest cure usually have difficulty in developing this attitude towards their illness.

The diet is an important part of the treatment. The emphasis has changed in the nutritional field from one of feeding the patient as many fresh eggs and as much milk as possible, to one of variety and balance. The aim now is to have the patient receive the required amount of minerals and vitamins. If the family is well-to-do, there need be little anxiety about the diet as any well-balanced home diet will suffice. But the diet assumes greater importance where the financial status of the family may determine how adequate or inadequate the diet may be. In this case, the nurse may find a solution by drawing up for her patient a list of good but inexpensive foods which will make up nutritious and balanced meals.

The patient should also receive instructions in a few practical details, such as taking her temperature, preparing sputum specimens to be sent to the laboratory, etc.

When the patient is well versed in her own personal care, she should then be instructed how to protect those around her from possible contamination. She must first be convinced of the contagious nature of the disease in order to stimulate her to the observance of precautionary measures with regard to others. In pulmonary tuberculosis, all excretions from the mouth and nose are a source of danger.

Therefore, the patient should be taught to cover her mouth and nose when coughing or sneezing; to receive all expectorations in sputum napkins that are deposited after use in a paper bag and burned; to avoid using her saliva to seal envelopes or stick stamps; never to wet the tops of her fingers to turn the pages of a book or cough through the pages of a book.

The nurse as a teacher has also a duty towards the family and relatives of her patients. They should be taught how to protect themselves from contamination. The person in the home who will care for the patient should be instructed as to the proper disposal of all contaminated matter; how to disinfect her hands; how to protect herself with gown and mask while giving personal care to the patient, making the bed, and sweeping the floor of the sick room. She should be told to keep the dishes separate, and to boil dishes and clothing. Children should not be allowed in the room.

Later as the patient returns to normal health there will come up the question of rehabilitation; but here the teaching and guiding will devolve mostly on the public health nurse.

From what has been said, it is easy to conclude that the role of the student nurse as a teacher is an important part of the community health program. The nurse, from the day she starts to wear her uniform until she leaves the profession, is a teacher of health. How well she performs her task is dependent upon her training and on her own native ability. So far, our schools of nursing have not given enough consideration to this phase of the nurse's training. They are gradually waking up to the fact that it is a very important aspect of nursing care and that the nurse who limits her activities to the physical care of her patients and fails to exercise her broader functions as a conserver and teacher of health cannot be considered fully competent.

Iron in Infants' Diets

Lack of iron in the infant's diet due to the shortage of eggs in some areas can be remedied by substituting for egg-yolk other iron-rich foods.

The Bureau of Maternal and Child Health has issued a leaflet recommending the following substitutions which are suitable for infant feeding and will supply significant amounts of iron to the daily diet:

Dark Karo syrup; molasses (contains twice as much iron as dark Karo syrup. White sugar contains no iron); whole grain cereals; Cream of Wheat (enriched); Pablum and Pabena; vegetables, such as green beans, peas, puree of dry cooked beans and lentils, greens, carrots; meat, especially liver and heart. (Pork liver contains five to six times more iron than calf and beef liver).

A full-term baby born of a well-nourished mother has a body store of iron at birth which usually lasts through the first three or four months of life. The iron needs of an infant under one year of age are estimated at 6 mg. daily. This need is met in the early months of life from the reserve present at birth. Later it must be supplied by foods of which egg-yolk is the most dependable.

—*California's Health*

Convention

The Biennial Convention of the Canadian Home Economics Association is to be held from July 2-July 5 at the Canadian Pacific Railway summer resort hotel, "The Pines", at Digby, Nova Scotia. A short refresher course on teaching methods will be held immediately following the convention.

Contributed by Hospital and School of Nursing Section of the C. N. A.

Nursing on an Eye Ward

ELOISE FLEMING

THE ADVANCE OF MODERN SURGERY in the field of ophthalmology has produced, in most hospitals, a special ward devoted solely to eye cases. The nursing care is of necessity a highly important adjunct to the surgeon's operative skill in restoring vision to blurred or sightless eyes. When we hear the remark, "eye nursing must be depressing", our first impulse is to deny it emphatically. We realize this statement may well be made following a quick tour of our eye ward, seeing bed after bed with a still, silent form lying flat on its back, head immobilized, and a large black mask tied over bandages that cover both eyes. The intense quiet that pervades the ward gives the suggestion of sleeping patients. Indeed, you can realize the nurses' dilemma in deciding whether the patients are asleep or not. They seem so placid and restful lying there waiting to regain their sight. There is a glorious recompense in restored sight which is perhaps second to no other recovery. The joy of success is an immense counterbalance to the sombre days of quiet, post-operative nursing.

If you would visit with us for "morning circle" you would be stimulated to a very worthwhile interest in ophthalmologic nursing. We spend about half an hour each morning discussing the current eye conditions and their nursing care. Early in the students' ophthalmology experience we discuss surgical eye cases and their nursing care. The first morning forum is a bit lengthy, but it forms a basis for further study and would lose much of its value if curtailed or broken up. This article outlines the main points brought up during this teaching period, using the care of cataract cases as our example.

The blackboard is of great value in this teaching. We have a small portable one which we bring into the office, and the students group themselves around it. "Diseases of the Eye" by Charles H. May, M.D., is our text, and its illustrations clarify references to the incisions and other parts of operations. A review of the anatomy of the eye is given, the difference between intra-ocular and extra-ocular surgery is explained, and the special post-operative care which *all* cases require following an incision into the globe of the eye is outlined. The extra-ocular cases do not need all the precautions applied in the intra-ocular ones. Among this type, we class all muscle operations, lid, lacrimal gland or duct surgery, that is, all operations on accessory organs. Under intra-ocular cases are listed all operations on lens, iris, retina, the extraction of a foreign body from the globe, or any other surgical treatment on structures within the globe.

Although the nursing care is the same for all intra-ocular cases, an exception is made in patients who have had an electro-coagulation of a detached retina to give them a longer period of bed rest and convalescence.

In a great many instances, the cataract extraction is considered the classical intra-ocular case. Without doubt, more cataract extractions are performed than any other intra-ocular operation.

The crystalline lens is normally a transparent body, biconvex in shape, suspended in the anterior portion of the eyeball between the aqueous and the vitreous chambers. It is held in position by its suspensory ligament, which extends from the lens capsule to the ciliary body. Any opacity of the lens or its capsule is known as a cataract. Cataracts may be classified into two main divisions: (1) *Developmental* (a) congenital (b) juvenile; (2) *Degenerative* (a) senile (b) traumatic (c) secondary. The patient comes to the doctor complaining of diminished acuteness of vision and disturbances such as "seeing spots", double vision, and myopia. If the cataract is mature and there are no complicating conditions the patient may be admitted for operation right away.

Pre-operative preparation of the patient consists of the usual enema at bedtime, a sedative one hour before he goes to the operating-room (usually luminal gr. 1½), and the instillation of the local anesthetic, pontocaine ½ per cent every three minutes for one-half hour before the operation is scheduled. The patient goes to the operating-room in his own bed which has a low top so that the surgeon can operate on him as he lies there. This is an important factor in reducing the hazards of *strain* to the eyes involved when moving a patient from the table to the bed. We call these cataract beds. A substitute can be arranged by placing the patient head to foot in an ordinary bed. We have developed a unique digression from the usual operating-room procedure. The head nurse or her assistant not only accompanies the patient to the operating-room, but dons mask and gown, sets up for the operation, and attends the surgeon throughout. This is an important advantage in the subsequent nursing care of the patient, for it gives the head nurse an "eye-witness" knowledge of the extent, condition, and any other features of the case. In this way, we are not blindly nursing a post-operative for whom previously we would only have had a chart record to reveal the nature of what took place in the operating-room. The head nurse then correlates this information in the report to her staff at morning circle.

Immediate care on return to the ward consists of putting sand-bags under the pillow on either side of the head to immobilize it, and specially cautioning the patient against lifting himself. A good eye nurse will make sure the patient fully understands how vital these precautions are to his sight. Vomiting, coughing, moving the head, or squeezing the closed eyelids are the leading factors in *straining*. These, the patient can materially aid in controlling himself. Nothing by mouth is allowed for at least two hours, then gradually a fluid diet is established for the next forty-eight hours. This removes the necessity of chewing, involving facial muscles which affect the eyes. Bed-baths are given for eight to ten days, although the patient is allowed up on the fourth day as a rule. A constant vigilance must be maintained over head movement whenever the position is changed, the pillows adjusted, or the back is rubbed. Turning must be toward the unoperated eye. The patient is instructed, when getting up, that bending over, stooping, or lifting heavy things must be avoided at all costs.

Since it is necessary to bandage and mask both eyes when the operation is done, the nurse must recognize her responsibility in doing everything for the patient, at least until the good eye is uncovered. The doctor usually cuts a window in the mask for the good eye at the time of the fourth daily dressing.

Complications that may develop in the eye are hemorrhage, opening of the wound, prolapsed iris, escape of vitreous humor, infection. The first four we group together as a direct result of *straining;* the fifth is almost negligible due to modern aseptic technique. Added to these are the complications that may develop in the general condition of the patient, such as retention of urine (from nervousness), confusion and groping adjustment arising from having both eyes bandaged, pneumonia, and cardiac symptoms. Most of these are easily avoided in the course of good routine care. The average time for hospitalization is two weeks, the last few days of which are spent preparing the patient for his re-adjustment at home. It is another four weeks before he can enjoy the full benefit of his successful cataract extraction with the fitting of new glasses.

There is so much that is interesting and stimulating in eye nursing—cataract cases with vision restored, glaucoma cases made free from pain, squint cases happy in their new beauty, or injured eyes repaired and saved. Always there is the everlasting hope and trust of each patient.

Candlelight Capping Ceremony

TWICE YEARLY, staff nurses, students, and the friends and relatives of the preliminary students of the School of Nursing of the Vancouver General Hospital gather together for the capping ceremony in the auditorium. It is most desirable that these young women should fully realize the importance of the step they are taking, and that the granting of "the cap" indicates not only individual fitness to begin the life of a student nurse, but also symbolizes allegiance to the greatest of all sisterhoods. It was, therefore, decided that realization of that allegiance should further be impressed upon their memory by the lighting of candles indicating the acceptance of the *spirit of service*.

On December 21 last, the walls of the dark old auditorium looked down upon a truly lovely sight. Forty-eight preliminary students, in "war-time" white with blue band on cuffs, stood to receive their caps before their relatives, friends, other students, and members of the staff who filled the auditorium to capacity.

A great Christmas Tree, gaily lighted, stood at the back of the hall, and between the preliminary students and audience, extended a long table decorated with shining holly and scarlet berries. The centre-piece was a mirror upon which stood a tall, white, unlighted candle in a Florence Nightingale Lamp candleholder, with a tall, red, lighted candle on each side. (Daffodils and tulips are the motif for the spring ceremony.) Surrounding the candles on the table were the forty-eight snowy caps awaiting their eager owners. After the singing of "O Canada" and "O Come All Ye Faithful", carols were sung by the preliminary students and an address of encouragement and congratulation was given by the Director of Nurses, Miss Elinor M. Palliser. Each student then came forward as her name was called by Miss Annie Cavers, educational director, received her cap, and returned to her place. Then all marched smartly out to don their caps for the first time.

All lights were extinguished. The tall, white candle in the Florence Nightingale Lamp was then lighted by the Director of Nurses. What a tiny light it was, flickering bravely in the darkness! Now followed the candlelighting ceremony. While Miss Eva Holley, a senior student, played soft music, each new junior student walked quietly into the auditorium and at the tall, white candle, lighted her own small, white candle and as quietly resumed her place. Gradually, as the small candles were lighted, the room grew brighter, until finally all the newly-capped juniors stood in a glow of soft candlelight, each holding her lighted candle so that all might see the happy face above it. Together they recited the simple pledge of loyalty to their chosen school of nursing and to the Spirit of Nursing they now represented, and together they sang that hymn of loyalty, faith and service—"Take my life and let it be"—a hymn which is so well suited to the thoughts and aspirations of the young nurse.

The president of the Student Council, Miss Olive Robertson, after congratulating the students, welcomed them into the school of nursing and reminded them of their responsibilities to their School and particularly to the Student Nurses' Association.

The ceremony closed with the singing of the National Anthem, and soon our new juniors were receiving the congratulations of their friends.

It was a simple but beautiful ceremony, full of the true meaning of the service of nursing—a ceremony which will always remain in the memory of the students themselves, and also in the memory of those who had come because of their interest in, and their affection for their young friends—the nurses of the future.

Obituaries

Kathleen H. Brock, who graduated from the Montreal General Hospital in 1900, died recently in Montreal after a long illness. After serving on the staff of the M.G.H. for many years, Miss Brock was employed as a private duty nurse.

Mary Ellen Byrne, formerly of London, Ont., died recently in Winnipeg. Miss Byrne had been engaged in nursing in Winnipeg for forty years.

Mrs. Sarah Dixon died recently in Vancouver. In 1917, when Mrs. Dixon was going overseas with the Canadian Army Medical Corps, her ship was torpedoed and she received head injuries from which she never fully recovered. Mrs. Dixon was a member of the Victoria Unit of the Nursing Sisters' Association.

Mrs. J. H. Jardine died at Lacombe, Alberta, after a lengthy illness. A graduate of the hospital in Guelph, Ont., Mrs. Jardine nursed for a number of years in Ontario before going west to a position at Provost, Alta.

Isabelle McCloskey died recently in Montreal after having been in ill-health for some time. Miss McCloskey graduated from St. Luke's Hospital in Ottawa in 1920. For many years she was on the staff of the old Ottawa Maternity Hospital. About seven years ago she joined the staff of the Royal Ottawa Sanatorium. She left there in 1944 and took a part-time position with the Royal Edward Laurentian Hospital.

Mrs. J. S. (Gray) Norton, a graduate with the class of 1933 of the Homoeopathic Hospital, Montreal, was killed in an automobile accident in New York State early this year.

Mrs. Janet (Rodgers) Ross, who graduated from the Homoeopathic Hospital, Montreal, in 1907, died recently in Ormstown, P.Q.

Alice Maud Sullivan, who graduated from the Montreal General Hospital in 1893, passed away recently in Montreal in her eighty-fifth year. Miss Sullivan had a happy, cheerful disposition, a keen sense of humour, and was beloved by a large circle of friends.

Mrs. Mary (Sherwood) Taylor, who graduated from the General Hospital, Galt, Ont., in 1901, died in December, 1945.

Deaths from Cancer

Among white female policyholders (ages 1 to 17), of the Metropolitan Life Insurance Company, the death rate from cancer, adjusted to discount the effect of the aging of the group, has been quite generally downward for about a third of a century. Among insured white males, the mortality from cancer, until very recently, had been increasing, although at a diminishing rate; but in the past few years it has also tended downward. —*Statistical Bulletin, July, 1945, Metropolitan Life Insurance Co.*

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Case Finding in Tuberculosis

ERMA R. TAIT

IN THE EARLY DAYS of the disease treatment alone was stressed, but today prevention, health education, and case finding are considered to be of major importance. Two of the most modern weapons used to discover tuberculosis are the tuberculin patch test and examination by x-ray.

We know that infection from tuberculosis is not accidental, that we do not pick up the germs while walking on the street, but that it is passed from one person infected with the disease to a healthy person. As there is close contact within the home, it is sometimes very difficult to control tuberculosis. For this reason, it is very important to discover the disease if it exists within the family or domestic workers, visitors, friends, or neighbours.

Often the clue to an unknown contact in the family is given when a child reacts positively to the tuberculin patch, a safe and harmless skin test. A positive reaction shows infection with tuberculosis from some source, perhaps within the family or beyond. It is important to emphasize the fact that children have relatively few chances to be infected outside the home. Therefore, a positive reaction to the tuberculin test should at once start a search within the family circle for the disease spreader. If this search fails to discover the sick person, then a more general search of contacts should be started.

At this point, I would like to tell you a true story of how a source of infection was discovered. Living in the home were the mother and father, three young boys, between the ages of ten and four years, and Frances, a little girl of two years. In addition, Margaret, aged eighteen years, worked as a maid at this home. Frances was convalescing from pneumonia. As her recovery was not as rapid as it ordinarily should have been, the doctor advised the application of a patch test; at the same time, one was applied also to Margaret. As both these revealed positive reactions, x-ray examinations were taken and, much to the alarm of the family, the little girl Frances was found to have an active childhood tuberculosis, or primary infection, while Margaret was negative. In order to find the source of the child's infection, x-ray examinations were made on the other members of the family. Fortunately, these were all found to be negative. Where next should we turn for the source of infection? On several occasions in the preceding months, Ethel, Margaret's sister, had visited at the home. Recently, because Ethel was not feeling well, a chest x-ray was taken, and this showed her to be suffering from active tuberculosis.

After reading this story, no detective would be required to trace the culprit who was the carrier of the "White Plague" to baby Frances—it was, of course, Ethel. At one of our recent clinics we found that Ethel was also the source of contact of five more children who were found to have primary infection.

Another patient about whom I wish to tell you is Mrs. A. During one of our school surveys, three out of seven children from that family were found to be positive reactors. X-rays revealed that all three children had primary infection. In all survey work, members of families with positive reactions are urged to attend one of the special clinics arranged for this purpose. This family co-operated and, after an x-ray examination, Mrs. A. was found to be suffering from tuberculosis. Here was our source of infection for these three children. The next important step was to prevent a further spread of disease to the healthy children. The home was small and there was no one to care for the mother except fourteen-year-old Mary and the father. Fortunately, because of the urgency of the case, within a month a bed was procured at the sanatorium. Many home visits were made to teach the mother how to protect her children and to persuade her to be admitted to institution for treatment. Naturally she did not want to leave her home and children, but she finally agreed to do so. After her admission to the sanatorium, her condition improved for a time and then, unfortunately, complications set in, and after a period of months she died. The children have been examined at six-month intervals and are to date in good health. This story once again shows the value of full co-operation of parents with the public health authorities, of having all children patch tested and, when necessary, examined by x-ray, and of examining all members of households where a child has a positive reaction.

Often considerable information regarding the patient's general condition can be procured by the nurse at these clinics. Practically every time a patient is discovered to have active tuberculosis, at least one home visit is made immediately. This is followed by further visits where necessary. Home visits cannot be evaluated in terms of numbers. When the patient and members of the household co-operate, it is not necessary to make as many home visits as it is when a patient refuses to carry out given instructions. When the patient and members of a household do not co-operate, they endanger their own and other people's health and also waste valuable time that the visiting nurse could use satisfactorily for other patients.

Now I will give you an example of a problem which concerns a patient outside the sanatorium. Two years ago, a young girl from the country was found to be suffering from active tuberculosis and was advised to rest at home. Soon afterwards, the public health nurse made a home visit and found the surroundings very inadequate. Besides the parents and the patient, there were six younger children in the small poorly-built home. Within a few weeks the girl was advised a bed was available for her at the sanatorium, but she refused to take advantage of this offer. The provincial government later granted her a monthly financial allowance. Frequent visits were made, but the patient was found at home only once and on that occasion she was in bed suffering from an attack of mumps. The mother had been advised each time about her daughter's condition and was told of the need for adequate rest, but the mother was most disinterested in any advice given.

About this time the health authorities received letters from people living in the vicinity. They questioned if it was dangerous for this girl to be visiting at their homes. One day, not long afterwards, a young girl reported for examination. She said that she was sleeping with a girl who had had lung trouble. Upon further questioning we found that our country patient was now working at a restaurant. The manager of the restaurant was informed about his employee, and after several warnings she finally reported for examination. Fortunately her condition was no worse, but she was advised to take regular rest periods at her home, not to work, nor to visit her friends. The nurse soon afterwards went to the home to find her absent and the parents would give no information as to her whereabouts. They said they could do nothing with her. Again a search was made and again she was found to be employed in another restaurant. She was rooming in a home where there were a number of young children, and in her leisure frequented the dance halls. The public health question is "How many people has this girl infected with tuberculosis?"

In the past, the Public Health Act of Prince Edward Island gave us some authority in dealing with problems of this kind, but not sufficient to prevent the patient from being a menace to the public. However, the Act was amended in 1945, with the result that the health officer now has more authority, which will help the situation.

Although the tuberculosis death rate is less than one-fourth of the figure of the first years of this century, though it has dropped from first to seventh place among fatal diseases, this disease still kills more people than any other communicable disease. Such a state of affairs will not do, government health services and the medical profession have decided. So a new all-out campaign has been launched against tuberculosis. It's "V-weapon" is that wonder machine of modern science, the x-ray, for mass radiography. Before a campaign for mass x-ray of the population is made, our people must be educated to the idea. We must use every channel possible—radio, newspapers, showing of pictures, etc. This x-ray is a painless, non-embarrassing scientific examination, at a cost within the reach of both rich and poor, and it will soon be made available by the Prince Edward Island Tuberculosis League. Many cases of pulmonary tuberculosis will be discovered before symptoms have developed and many lives can be saved. Such great strides have been made in the medical, surgical, and therapeutic treatment of tuberculosis that the disease is almost always curable if discovered in the early stages. The great problem is, therefore, one of procuring prompt diagnosis of an active tuberculous condition. Many folk, if the matter is left to chance, do not realize that they are ill until the disease is too far advanced for complete cure, perhaps even for effective treatment.

Mass x-ray examinations of all the people obviously will take most of the chance out of the tuberculosis problem. Not only does the mass x-ray system enable thousands to obtain treatment and speedy cure early in the progress of the disease, thus saving their own lives, but it removes them as a source of grave danger to others.

Institutes at the University of Western Ontario

February 20-22, 1946, a refresher course was held at the Institute of Public Health, London, Ontario, on the subject of "The Place of the Nurse in Community Planning." This course was financed through the Federal Government Grant. It was a conference open to all those agencies which give field experience to the students at the University of Western Ontario in nursing education and in public health nursing. It was found very valuable to both the university and those giving the experience, as it ultimately will enrich the field experience of the student because of a better understanding of the objectives and the methods of experience in the field. Nurses were present from such distant points as Cochrane, Timmins, Kirkland-Larder Lake Unit and western Ontario where field experience is provided, with a total enrolment of 116.

Three other refresher courses were planned at the University of Western Ontario. The first was March 27-29, 1946, for the registrars of Community Nursing Registries in Ontario. The guest speaker at that time was Dr. Frances A. Triggs, consultant for

Nurse Placement Service, American Nurses Association. Assistance was given by Miss Madalene Baker, adviser to Community Nursing Registries in Ontario, and Miss Mildred I. Walker, chief of Division of Study for Graduate Nurses. Registration was limited to registrars and those in related services.

From April 15 to 18, a course is arranged for the Ontario Division of the Red Cross for the graduate nurse volunteers who assist in their program in Ontario. The visiting speaker is Miss Freeda Held, director, Women's Volunteer Services, Department of Health and Welfare, Ottawa. Other speakers from the university and vicinity will assist.

During the week of May 13, a refresher course in Industrial Nursing is being planned by the university at the request of the Division of Industrial Hygiene, Ontario Department of Health. Miss Sarah Wallace, the nurse consultant, will assist in the program and arrangements. The visiting speaker will be Miss Lucille Harmon, M.A., assistant professor of nursing, Wayne University, Detroit. There will be others assisting.

Sensory Aid for the Blind Being Developed

Development of a sensory aid for the blind which operates on electronic principles akin to radar, and which was first initiated at the request of the Surgeon General, has reached an advanced stage, according to an announcement by the War Department of the United States.

The experimental model, weighing nine pounds and connected with a single earphone, contains a three-watt lamp which focuses a narrow ray of light through a lens. Any object within twenty feet of the device will reflect the light back toward a second lens, which, in turn, transfers the light to a photoelectric cell, divided into five units for computing distance. The cell then produces electrical bursts of energy or sound tones and these are transmitted to the ear through a standard hearing device. The handle of the device is parallel to the direction of the first light ray, enabling the user to detect, through the position of his hand, the direction of the object.

Although the laboratory model of the device has been completed and tested at Signal Corps Engineering Laboratories, it is not yet considered sufficiently perfected to be practical for use, and requires further development before being placed in production.

—*News Notes No. 32*

Renewal of Nurse Registration in Minnesota

By requirement of the Minnesota law, effective July 1, 1945, all Minnesota registered nurses must renew their registration annually if they wish to maintain their status as Minnesota registered nurses. Every Minnesota registered nurse was informed by mail of the state regulations and was sent an application form, but thousands of letters have been returned to this office unclaimed because of inadequate addresses.

Every Minnesota registered nurse who has not received her application form should so notify the Minnesota Board of Examiners of Nurses, 222 Minnesota Building, St. Paul, 1, Minnesota, at once. Her application form, which will be mailed to her, must be returned to this board stating whether she wishes to renew her Minnesota registration (renewal fee $1) or whether she wishes to be placed on the non-practising list, in which instance no renewal fee is required. Other pertinent information is included. It is extremely important that she return her application form to this board whether she is active or inactive.

Nurses having served or serving with the armed forces should return their application form, but no fee is required for the duration of the war and one year thereafter.

—Leila Halverson

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Specialling a Hemiplegia

DOROTHY SMITH

ON AUGUST 2, 1945, I was called to attend a cerebral hemorrhage case. My introduction to the patient came with a bang when I was met at the door by an old man of seventy-five waving quite deliriously at me while his hospital gown flapped above his knees. Presuming he was the patient, I put him back to bed.

Mr. O remained for two weeks quite delirious and violent, becoming quiet only at intervals when given morphine sulphate gr. ¼ or nembutal gr. 3. Periodically he almost seemed to develop an idiosyncrasy to these drugs.

Previous to hospitalization Mr. O had been indulging too freely in alcoholic beverages and would repeatedly refuse food. It was with great difficulty that we finally cut down on his liquor intake. From then on he became less violent with attacks coming only once in a long while.

His nights and days were almost sleepless. His right leg and arm were paralyzed. His speech was almost a growl, so run together and jumbled were the words. His toilet habits would have been good if we had been able to make out what he wanted. Finally we realized that when he became excited and thrashed at the bedsides this was a sign that he wished to have the pan or urinal.

By the second month, Mr. O was sitting up, eating his meals, and trying hard to talk. He recognized his nurses and his daughter but others still seemed to be a perfect blank to him. He would wave his hands furiously and keep up a chatter which was completely unintelligible.

During the fourth month, we massaged his whole right side putting special emphasis on the leg and arm. The massage seemed to help and we noticed Mr. O beginning to move his arm first and finally his leg. We encouraged him to hold things in his right hand and made it a habit to give him his daily ration of beer only if he would hold his glass in his right hand.

The second week of November Mr. O sat on the edge of the bed each day and put a little weight on his right foot. By the end of November, our patient was walking from his bed to the chair with little assistance. Much to our satisfaction Mr. O was walking from his bedroom to the dining-room for his three meals by the first of December.

January 7, 1946, I came off the case leaving the patient with a hearty appetite and walking about with just the aid of a cane. We noted that if he became excited his speech became rather jumbled, but otherwise, for a man of his years, he seems to be enjoying good health.

Interesting People

Edna Hewson, a graduate of the Hospital for Sick Children, Toronto, has recently been appointed to a new position in Ontario, that of inspector of Hospital Obstetrical Services for the Department of Health of the Province.

Miss Hewson went to New York for postgraduate work at the completion of her training, and then accepted a position at the Mount Sinai Hospital, Cleveland, in charge of a medical and orthopedic unit. In 1929, she returned to the Hospital for Sick Children in charge of a medical floor, and three years later took over the infant ward, a 60-bed unit, where she remained in charge until her present appointment. During this time Miss Hewson acquired, through her keen interest, an intimate knowledge of the many clinical types admitted to her ward. Her judgment, profound experience, and never-failing interest in each baby, made her an invaluable supervisor in one of the most exacting and detailed fields of nursing. With her wide experience in clinical administrative work, she should prove to be a consultant of very real assistance in solving many of the problems met in the busy obstetrical departments of the present day.

Since her latest appointment Miss Hewson has spent several weeks observing the practice in obstetrical units in hospitals in New York, Jersey City, Philadelphia, and Hartford, Conn.

Margaret Pringle, a graduate of the Royal Victoria Hospital, Montreal, has recently assumed the responsibilities of superintendent of the James Hamet Dunn Hospital, West Bathurst, N.B.

Margaret Pringle

Born and educated in New Brunswick, Miss Pringle began her professional career as a private duty nurse. After a brief period as superintendent of the Victoria Public Hospital, Fredericton, N.B., she enrolled at the McGill School for Graduate Nurses, receiving her certificate in teaching and supervision in 1928. Her first appointment as instructor was at the Deaconess Hospital, Buffalo, followed by five years at St. Luke's Hospital, Marquette, Mich., and two years at the Moncton Hospital. In 1937, Miss Pringle returned to St. Luke's Hospital as superintendent of nurses. For a brief period after her return to New Brunswick, Miss Pringle was travelling instructor there and in Prince Edward Island. Early in 1945, she undertook the organization of Nurse Placement Service for the N.B.A.R.N. She attended the institute on placement service in Winnipeg last autumn.

Miss Pringle is one of those who enjoys "exploring", when off duty. Perhaps it will be in libraries or in museums, in antique stores or on the highway, (she has driven by car from the Lake Superior region to the Atlantic seaboard ten times by divers routes); wherever she goes she takes a keen pleasure in her surroundings. Good luck in your new assignment!

Constance Judith Bratrud, Canadian-born of Norwegian parentage, has recently become the matron of the Chilliwack General Hospital. Educated in Alberta, Miss Bratrud graduated from the Misericordia Hospital, Edmonton, in 1938. Post-graduate study in surgery was taken at St. Paul's Hospital, Vancouver.

After experience as matron of the Municipal Hospital, Spirit River, Alta., and as nurse-in-charge at the Doctors' Clinic, Holden, Alta., Miss Bratrud moved to B.C. For four years she was attached to the staff of the General Hospital in Powell River, moving from general staff to operating-room supervisor and finally to the position of matron, which post she occupied for two years. During her sojourn in Powell River, Miss Bratrud took an active part in the work of the local chapter of the R.N.A.B.C.

Miss Bratrud is an outdoor enthusiast and finds her relaxation in fishing and swimming.

Anne d'Halewyn has returned to the medical department at The National Breweries Limited in Montreal, following her discharge from the Royal Canadian Army Medical Corps. She joined the R.C.A.M.C. in 1942 and left for the United Kingdom in August of that year. She served with the 17th and the 10th Canadian General Hospitals for eighteen months, after which she was posted to Italy where she was attached for six months to the 16th C.G.H. She was brought back to the United Kingdom with the 23rd C.G.H. and shortly after was repatriated to Canada and posted to the Longueuil Military Hospital in September, 1944. In April, 1945, she was posted to the Canadian Hospital Ship, *Letitia*, aboard which she remained until she was placed on the retired list.

Educated in Montreal, Miss d'Halewyn was trained in St. Mary's Hospital in New York. She has been associated with the medical service of The National Breweries Limited since October, 1930.

Dora Parry was recently honoured on the occasion of the celebration of her twenty-five years' association with the Children's Memorial Hospital, Montreal. Entering the school of nursing of that hospital as a student nurse in 1921, Miss Parry joined the staff, upon graduation, as operating-room supervisor. In 1930, she entered the McGill School for Graduate Nurses and received her certificate in administration in schools of nursing. Returning to the Children's Memorial Hospital, Miss Parry served as assistant superintendent of nurses until 1938 when she became superintendent of nurses.

As a token of their esteem, the Executive Board of the hospital presented Miss Parry with a white gold, diamond-studded wrist watch and twenty-five American Beauty roses. Later, at the evening reception, Miss Parry received an engraved silver sandwich plate from the Staff Nurses Association.

Miss Parry has always taken an interest in nursing association affairs. At the present time she is chairman of the English-speaking Hospital and School of Nursing Section in the R.N.A.P.Q. Despite her busy life, Miss Parry has found time to develop a woodcarving hobby. We join with her colleagues in wishing her many years of happy, useful service.

CONSTANCE BRATRUD

Christina Murray Macleod, affectionately known as "Cloudy" to her intimate friends, has severed her connection with the Brandon General Hospital after almost thirty years of service, first as assistant superintendent and, since 1923, as superintendent.

Born at Stornoway, Isle of Lewis, Scotland, Miss Macleod received her preliminary education at the Nicholson Institute as a scholarship student. She graduated from the Brandon General Hospital in 1908 when Mary Ellen Birtles, O.B.E., was superintendent. Miss Macleod took joy in the fact that a grand-niece of Miss Birtles is a student in the B.G.H. at the present time.

Following graduation, Miss Macleod engaged in private duty for a number of years. By way of expanding her interests, she attended the Manitoba Agricultural

Rapid Grip & Batten

ANNE d'HALEWYN

HARRIET ACTON

College and secured her diploma in home economics. During the winters of 1914-15 she lectured throughout rural Manitoba under the auspices of the Women's Institute. One of Miss Macleod's ambitions, now that she has retired from active nursing, is to return to university to pursue further studies in home economics.

Miss Macleod has held numerous responsible offices both in the M.A.R.N. and in the Brandon branch. In 1925, she represented Manitoba at the I.C.N. congress at Helsingfors. She received the George V medal in 1937. Her club affiliations are numerous, including the Canadian Club, I.O.D.E., Business and Professional Women's Club, etc.

Miss Macleod's interest in nursing is as strong as ever. Since she retired, she has written the history of her beloved hospital, tracing its development through the early days and recording many an interesting story of the first graduates.

We all wish Miss Macleod long years of continued good health and happiness.

Harriet B. Acton, a graduate in 1910 of the Royal Alexandra Hospital in Edmonton, has retired from her post with the Tuberculosis Clinic in Calgary where she has been nurse-in-charge since 1928.

Following her graduation, Miss Acton was appointed as a charge nurse at the R.A.H. where she served until she joined the C.A.M.C. in World War I. Upon her return from active service, Miss Acton was appointed night supervisor at St. Luke's Hospital, Spokane, Wash. She filled this position until her work at Calgary was undertaken.

Miss Acton is a member of the Nursing Sisters' Association of Canada and of the Women's Canadian Club.

VERA PEARSON

Vera Pearson, who graduated from the school of nursing of the Toronto General Hospital in 1918, resigned recently as superintendent of nurses at the Woman's General Hospital, Montreal. Educated at Loretto Abbey, Toronto, and at the Ottawa Conservatory of Music, Miss Pearson received her certificate in administration in schools of nursing from the McGill School for Graduate Nurses in 1932.

Following her graduation, Miss Pearson served as a staff supervisor at the Toronto General Hospital for eight years. In 1926 she became assistant superintendent of the Brantford General Hospital. Three years later she was appointed superintendent of nurses at the Wilson Memorial Hospital at Bimington, N.Y. Prior to coming to Montreal in 1936, Miss Pearson was for a time superintendent of nurses at the Regina General Hospital.

Miss Pearson is a member of the Themis Club and of the Women's Canadian Club in Montreal.

Preview

In these days of crowded hospitals, the problems of the admitting office nurse are multiplied a thousandfold. Yet there are enough compensations to make it a satisfying piece of work to **Josephine Morgan** who has described her various duties for us under the caption, "The Admitting Office Nurse in Action."

AUX INFIRMIERES CANADIENNES-FRANÇAISES

Une Technique à la Salle d'Opération

Soeur Marie-Elide, f.c.s.p., G.M.E.

Introduction: Nous sommes quelques fois étonnés en visitant de petits hôpitaux plutôt éloignés des grands centres, des techniques modernes qui existent dans certains départements.

Même avec un personnel restreint et avec des moyens très simples l'on peut arriver à un but déterminé, comme le démontre le travail présenté par Soeur Elide.

La compétence, l'intelligence, la psychologie sont les causes du succès.

Au cours des interventions chirurgicales, un point très important pour l'infirmière est la surveillance des compresses dans tous les cas où une distraction entraînerait dans une plaie profonde, un oubli fatal.

Afin de remédier à cet accident, il est du devoir de l'assistante à l'opération de compter minutieusement le nombre des compresses dans tous les cas où un danger pourrait exister.

Différentes méthodes sont usitées à cette fin; la plus simple consiste, après l'ouverture de la plaie, à n'employer que des compresses montées sur un

Compresses sur la table		
Compresses ouvertes		
Compresses lapar		
Avant la fermeture de la plaie:		
Compresses sur les tables		
Compresses dans les bassins		
Compresses lapar		
Total		
Instruments		
Pinces Pean		
Pinces Kocher		
Pinces à dissection		
Pinces Allix		
Aiguilles		
Total		

Sponge holder, et des grandes compresses, appelées communément laparatomies, auxquelles on attache au galon fixé à cet effet un anneau ou une pince. La garde-malade devra présenter au chirurgien, au cours de l'intervention une compresse sur une pince ad hoc et ne pas accepter cette même pince dépourvue de sa compresse sans avertir, ce qui en assure la surveillance. D'après cette méthode, seul le nombre des laparatomies sera compté, ce qui simplifie le travail.

Tous les médecins n'ayant pas l'habitude de se servir de *Sponge holder*, depuis quelques années nous employons avec succès un tableau noir appendu au mur de la salle d'opération dont voici le modèle.

Dans la première colonne la garde-malade faisant le service externe, inscrit le nombre des compresses employées avant et pendant l'opération; la dernière colonne sert à noter le nombre des compresses après l'opération pour les vérifier.

La garde-malade doit marquer avec soin les compresses ajoutées au cours de l'intervention; chaque paquet comptera invariablement le même nombre: soit douze pour les compresses ordinaires et deux pour les laparatomies qu'il faudra par prudence vérifier de nouveau avant de les inscrire.

Chaque chirurgien dans certains hôpitaux, a ses instruments personnels et une technique spéciale; il est nécessaire alors d'en faire mention au tableau tel que ci-dessus.

Il est du devoir des infirmières de prendre conscience de leurs responsabilités.

Advienne un accident, le chirurgien serait privé de ses assurances si l'habitude n'existait pas de prendre note du nombre des compresses et des instruments.

Dans les différents services, l'attention et l'esprit d'observation sont nécessaires à la garde-malade; nul département plus que la chirurgie ne requiert ces deux qualités professionnelles.

Puisse l'infirmière ne jamais oublier que le présent seul est réel, et que chaque moment a une valeur d'éternité.

Comparing Preventive Medicine in Korea and Canada

D. B. Avison, M.D.

SANITATION and preventive medicine in Korea are still in their infancy. However, definite progress has been made in the past twenty or more years. While some of the things may sound ludicrous, others, if given a little thought, will also be found sensible and perhaps hold a lesson for us.

DISEASES

Korea has all of the communicable diseases that are common to us, plus dysentery, leprosy, and malaria. The dysentery is mostly due to the *Ameba hystolytica* though there is quite a lot of bacillary dysentery also. Leprosy is common enough for everyone to have seen its victims, many of whom wander about the country as social outcasts begging for food. At least every Christmas a group of them called on us for money and food. The average person is far more afraid of leprosy than he needs to be for it is not easily spread, requiring long periods of close contact to acquire it. If treatment is started early many cases can be cured. The fear of ostracism unfortunately, as with venereal disease in our country, tends to make people delay reporting to a doctor till too late. In Korea there were three mission leprosaria with about four hundred lepers in each—men, women, and children. They were encouraged to live normal lives. They had homes, schools, churches, and hospitals. In order to have as normal a home life as possible, marriages were allowed after the men had been sterilized. Leper children were given to the couples to rear. Leprosy in Korea is of the anesthetic type and, while deforming, is painless. Some cases are cured; the rest may live for many years with proper treatment, good food, and homes.

Typhoid fever and dysentery are, as you know, filth diseases, due to the swallowing of fecal material. This is just as true in Canada as in Korea. This fecal material may be in the water or milk we drink or on the food we eat. It may be introduced by human means or by flies. We seldom know who the carriers of typhoid germs are and because our milk seems reasonably clean we drink it with confidence. Some of our friends insist on drinking raw milk because they think it is more healthful than pasteurized milk, or think they like the taste better. In Korea, the people dislike the taste of any animal milk. They only drink it as a medicine, and then only when it is boiled and still hot. At least they do not get typhoid fever, dysenteric diseases, scarlet fever, diphtheria, septic throats, or bone and intestinal tuberculosis from milk, all of which may be traced to our blind adherence to drinking raw milk in this country.

Dysentery and typhoid fever are common in Korea because of water infected by carelessness in ordinary sanitary habits. Fields are manured with human fecal wastes; these wash into the streams and in these streams the farmers wash their vegetables. I remember in a typhoid epidemic the wise advice given by Dr. Oh. Dr. Oh said that if the housewives would buy dirty vegetables at the market instead of clean ones they would have no typhoid. The clean-looking vegetables had been washed in the heavily-polluted wayside streams while the dirty-looking vegetables came straight from the fields, still soiled with earth in which nature's soil bacteria had destroyed the pathogenic organisms. Of course, a great deal of typhoid fever in Korea comes from wells that are subject to pollution. It is strange how many people even here in Canada will drink water without questioning its source. Like raw milk it looks and tastes good so what is the difference? We, in public health, say that the typhoid rate in a community is an indication of the state of civilization it has reached. With our present knowledge of how typhoid is spread no community should permit the continuance of this disease.

While the authorities in Korea know how typhoid and dysentery are spread, in some respects they fail to use their knowledge. In all communities of any size there are modern water systems, with chlorination done in all cases. This has greatly reduced the incidence of typhoid fever and dysentery. One result of living in a totalitarian country is that, being undemocratic, the public is not asked to vote on what is good for it—it is simply done! Thus no one is asked if he wants chlorinated water—it is just done, and that is all there is to it. Unfortunately, while plugging this hole they leave others wide open. Thus, wells subject to pollution are allowed even where chlorinated water is available. Human night-soil is a valuable manure. In Seoul, the capital city, the night-soil is collected in huge vats and sold to the farmers. I have seen these farmers wade into it up to their armpits to get what they consider the most valuable manure in the centre. The sanitary officer in charge assured me that this was a safe practice, yet I pictured typhoid, dysentery, hookworm, and many other diseases resulting from it.

In Korea, they recognize flies as carriers of disease and spend money and effort in killing them. So much money is paid for every cupful of flies caught. In the garbage dumps they trap the flies in tin-lined, little cages into which the flies swarm at night to escape the chill of late summer and early fall nights. At the same time, the Koreans do little to do away with their breeding places by adequate disposal of garbage. In Korea, bed-bugs and lice are so common that folks do not get excited about them. Here in Canada, bed-bugs and lice are of little consequence as disease carriers yet our women nearly go into hysterics if they find any in their homes or on the persons of their families. At the same time we view the common fly, which we know to be an active carrier of disease, with little concern. In the restaurants, flies wander over sugar and pies, and if they happen to drop into our soup, tea, coffee, or milk, many people fish them out and finish their drink.

In Korea, they recognize that a dirty home may be a source of disease. The authorities found it difficult to go to individuals and tell them that their homes were dirty and must be cleaned even as we find it difficult. They decided that at least twice a year every home must be cleaned. No service club sponsors a "clean-up week" urging the people to burn up their garbage or to purchase garbage cans. In a totalitarian country it is a much more simple matter. The nation is simply ordered that a certain week is "clean-up week" and the contents of every house must be put out-of-doors. The house and contents are thoroughly cleaned. This is done twice a year—spring and fall. No questions are asked, no insinuations made. Clean and unclean people alike perform this bi-annual rite and the police call at every home to see that it is done. Many of our missionary ladies resented this order at first until they recognized its universal value. How often I have wished that in this country we had a compulsory "clean-up week" twice a year! It would save embarrassment, hard feelings, foul language, and would get rid of a lot of rubbish that constitutes a constant fire hazard.

Preventive medicine in many ways may be at its beginning in Korea, but what is done is done thoroughly. Annual immunization against smallpox is the rule and typhoid and cholera immunization are done in times of threatened epidemics. When I say it is the rule, I do not mean that smallpox vaccination is the law, as in our country where we go around begging for "consent cards." When immunization week for any disease is announced police stand at every corner and stop every passer-by to see if he carries a certificate of immunization dated in the current week. If this is not found, the person is then and there given the treatment by the police. As might be expected such crude methods are often followed by infection. Realizing this, many of the people rush to the doctors to be immunized and obtain a certificate that will save them from the police. This way of doing things may be hard but I saw smallpox practically wiped out in a nation of twenty-two million people, where thirty years ago it was more common than chickenpox in our country.

I hope I do not seem to advocate the methods used in Korea as a general practice but I do think that where it has been proven that certain measures are necessary for health, these measures should not be obstructed by the ignorance of the public. I have found many old country people who refused to have their children vaccinated. When I asked them if they had not been done they replied, "Of course, but it is the law in England." In Ontario it is the law that every child must be vaccinated before the age of three months. Yet we present the parents with consent slips and if they refuse to sign, we let them go. We should remember that every refusal not only constitutes a danger to the child in question but to the community. This is certainly true of diphtheria. Our health acts are cluttered with the laws that we have no direct means of enforcing. An example is the milk act in B.C. The health authorities are clamoring for milk control in the hope of making pasteurization compulsory. Yet if we had carried out the milk act as it exists I believe fourfifths of our milk today would be pasteurized. It is obviously uneconomical for most of our raw milk dairies to raise their equipment standards to Grade A requirements. It is now possible for a community in B.C. to require pasteurization by a majority vote of its citizens. Some will do so but most, unless they have had a recent epidemic to jar them, will, like the Lotus Eater, prefer to enjoy their present status without concern for the future. Our municipalities have sanitary by-laws but a suggestion that they be enforced when necessary, by resort to the courts, raises an immediate storm. In my opinion one or two court cases would, after the first flurry, do away with most of the necessity of court actions and result in better co-operation.

In all of these measures of sickness prevention the need for help from each of us concerned with health is urgent. Let us pass up no opportunity to stress the need of fly control by adequate garbage control, or the ease with which we might rid ourselves of, or greatly reduce the incidence of, whooping cough or scarlet fever, and continue our freedom from diphtheria and smallpox by the widespread practice of immunization measures. We can ensure the elimination of typhoid fever and much of our diarrhea complaints by adequate attention to our milk and water.

Canadian Nurses—What of your Future?

EILEEN MAYO

CANADA IS FAST BEING RECOGNIZED as one of the leading countries in world economics, and especially will this be true in the post-war world. To do an efficient job of this sort the primary interest of the country should be in the health of her people. This is being recognized more than ever, and it will be the duty of every nurse in Canada to take her share of the responsibility.

There is nothing in this world, man-made, so good that it cannot be improved. Just so the nursing organizations of our country. For instance, why should each province have its own registration examinations? Would it not be much easier for all concerned to have Dominion-wide Registration examinations, thus enabling nurses to travel through their country, improving their education and experience by travel, to work in any province without having to obtain a different registration? During a shortage of nurses, such as we are facing right now, it would be a much greater inducement for nurses, who have not been engaged in their profession for some time, if they merely could come out of hiding and go back to work, without having to worry about writing here, there and everywhere to obtain registration, if they graduated in some other province.

The need and value of all nurses, whether graduates or practical, is being seen more and more. The danger of some nurses, who have taken only a few months' training or some home nursing course, of trying to obtain work as fully-trained nurses is pointed out to us frequently. If all these nurses registered according to the amount of training they have had, we would not need to worry about some of the more indiscreet of these endangering the public by going to work as graduates. It would also be of immense value to hospitals and other organizations employing them.

One of the major problems and perhaps the one under constant discussion, both amongst nurses and their employers, is the ever-burning question of salaries. Here again, would not a stabilization of salaries, based on education and experience, for the Dominion be the rational thing to do? Surely a person with a University degree and years of experience deserves a considerably larger remuneration than the nurse who has just graduated. And surely the nurse who has just graduated and put in three years' hard work and study deserves more remuneration than the unskilled person working in a factory or doing housework.

The course of studies in the training schools is a full one now, but with the present-day trend of war casualties, broken homes, and all the hundred and one other problems left over from the war, could more time not be allowed for stronger emphasis on such subjects as public health, psychiatry, and social welfare? All nurses at some time or other come up against the need to understand people and their problems, and perhaps would be better equipped to help if more stress were placed along these lines.

For the nurse who wishes to specialize along one particular line of nursing a post-graduate course is necessary. For the average person it is not easy to take a whole year off from work and finance a post-graduate course. Already in one province, summer courses are being tried out to obtain certain post-graduate diplomas. More of these summer courses across Canada would make it possible for many more nurses to take further study along the line of work in which they are most interested. Summer courses also have the advantage of giving the nurse a clearer idea of problems which will face her, by having a longer period of practical work in the field between the first half of her course the first summer, and the return to the theory again seven or eight months later. More post-graduate courses could also be taken by the granting of scholarships instead of presentation of medals at time of graduation.

The public are amazingly ignorant of the value of the public health nurse, and very few people realize she is a graduate nurse. The value of her work to the community could be made much more widely known by advertisement. Tell what she does, her qualifications, how to get in touch with her, and make the people realize that she is working for their benefit, and that they are helping pay for her services through taxes. This can best be done through the work of posters, newspaper advertisements, and a day a year set aside and known as "Public Health Nursing Day."* Tell people about her and they will be interested in her, but as long as they don't know she exists they never can be interested in her or her work.

In conclusion and with reference to all realms of nursing, please nurses, dress and look the part. It is such poor advertisement for a nurse in uniform to look grubby, ill-kempt and down-at-the-heel. We all know at the end of a day's work no one feels any too spry, but that is no excuse for run-down heels, sloppy hair-dos, and ungainly carriage. Whether in uniform or not, as soon as the public know you are a nurse they expect or hope to see something resembling the popular conception of the freshly-starched looking individual rushing around doing her bit for the good of humanity. And it will make your work much more interesting, too, if you feel you look like that popular conception.

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* *Public Health Nursing*, May, 1945, p. 227.

Preview

Many nurses have a distinct aversion to anything that savors of an arithmetic problem or the handling of any sums of money excepting their own pay cheques. Few know the rudiments of bookkeeping or even that there is any distinction between revenue and receipts or expenditures and disbursements. Yet many nurses have a considerable responsibility for the finances either in one of our smaller hospitals or in a public health nursing organization. To all of these, the series of three articles by **Percy Ward** on "Accounting for Nurses" will be of welcome assistance. The first article of the series will be featured in the May issue.

Notes from National Office

General Meeting—1946

THE TENTATIVE PROGRAM for the Twenty-third General Meeting of the Canadian Nurses Association will appear in the May issue of *The Canadian Nurse*. It is hoped that every provincial Nurses' Association will be well represented at this meeting. There are many outstanding speakers on the program and topics that will be of special interest to each and every nurse in Canada, whether she be engaged in private duty, general duty, institutional, or public health nursing.

Convention headquarters will be at the Royal York Hotel, Toronto, July 1-4, 1946. Reservations should be made well in advance. Room rates at the Royal York Hotel are as follows: $3.75 per person, two in a room; $3.25 per person, three in a room. (No single rooms are available.) Reservations have been made through National Office for the Executive and provincial official delegates. There are available rooms at the Royal York and other hotels for members-at-large.

Visit to Prince Edward Island

The general secretary spent one week in February in Prince Edward Island, visiting hospitals and sanatoria. An institute was conducted on the development of a professional organization. Conferences, interviews, and informal discussions were held with medical staff, members of the hospital, and public health organizations on the Island, and a conference with the Premier and with the Minister and Deputy Minister of Welfare and Health.

The general secretary had the opportunity of addressing the nurses of the Prince Edward Island Registered Nurses Association at their quarterly meeting held at Charlottetown, February 11. A fifteen-minute radio talk was also given at Charlottetown on the nursing situation in Canada.

A great deal of interest was shown by all the nurses on the Island in the development of their Association. It is hoped that a full-time secretary-treasurer, registrar, school of nursing adviser, and director of placement bureau will ultimately be obtained for Prince Edward Island.

Department of Veterans Affairs

A bulletin from the Department of Veterans Affairs, Treatment Services, regarding Tuberculosis Nursing, received recently, contained the following notice for attention of nursing staff, D.V.A. Hospitals:

"All professional nurses recognize the fact that the fear of nursing a disease is completely dispelled when a nurse has had thorough instruction and training in the handling of any particular disease such as scarlet fever, diphtheria, and smallpox. In other words we have changed the attitude toward the nursing of infectious diseases since the day of the 'pest house' by properly conducted infectious disease affiliation courses during the nurse's basic training.

"Unfortunately, at this time, when so many of our veterans have contracted tuberculosis, nurses have not had proper or adequate training in sanatorium nursing of tuberculosis during their basic nursing training, nor are there sufficient nurses available with tuberculosis post-graduate courses, and too many nurses are afraid, because of their lack of knowledge and technique, to do tuberculosis nursing.

"The Department of Veterans Affairs recognizes this hesitancy on the part of nurses to do tuberculosis nursing, but on the other hand it is faced with one of the most serious of nursing shortages in this specialty, and if our veterans are to be cared for properly it is absolutely imperative to have more T.B. trained nurses in our hospitals.

"Therefore, in order to offer an opportunity to our nurses to take post-graduate study without having to take leave of absence to do so, the Department of Veterans Affairs has secured the co-operation of the Hamilton Mountain Sanatorium to conduct a 2-3 month post-graduate affiliation course which will take twelve D.V.A. nurses at a time for post-graduate study in tuberculosis nursing. A certificate will be issued by the Sanatorium at the successful completion of the course by any D.V.A. nurse, and the course will be credited by the D.V.A. as a post-graduate course in this specialty.

"Our aim in arranging this course is to enable the nurses who have been working in our T.B. divisions an opportunity to secure a *bona fide* post-graduate course, as well as to help us establish correct sanatorium methods in our own D.V.A. T.B. hospitals and divisions. Our *key* people should go first.

"It is the wish of the Director of Nursing, Ottawa, to have all the Matrons bring this to the attention of all the nurses employed in D.V.A. hospitals, and prepare a list of the nurses who would be interested in taking such training.

"The course will be given to our nurses with the understanding that they will be available for employment in our T.B. hospitals and divisions for at least one year after completion of their course."

The director of nursing for Director General of Treatment Services, D.V.A., is hoping for a good response, and an early reply from you concerning the nurses interested in taking advantage of this order.

Australia

We regret to read that the efforts of our Australian colleagues to secure a decision from the Arbitration Court under the National Security Regulations, regarding the matter of salaries and conditions of employment of nurses, met with failure. The judge's decision was reached on the basis that nursing did not come under the jurisdiction of the Industrial Peace Regulation. Reference was made to the rulings the nurses hoped to receive in the December, 1945, issue of the *Journal*.

There appears to be a possibility that the Government in Australia will attempt, by a referendum, to have referred to the Federal Parliament power to legislate with regard to public health. If this should be done, it might be possible to secure a Federal Nurses' Act which would refer conditions of employment and salaries of nurses to a special commission.

New Zealand

We note in the December, 1945, issue of *The New Zealand Nursing Journal*, a detailed report on revised salary scale for nurses. This is very clearly outlined, with the ward sisters' rates clearly defined, and is progressive in accordance with experience and additional qualifications required in any specific position, e.g., obstetrics, plastic nursing certificate or post-graduate course, 10 pounds yearly added to salary.

Ten pounds yearly is added for additional qualifications, as stated above. It is interesting to note that

SALARY SCALE, NEW ZEALAND

Matrons are arranged under the following classification:		
Class I	over 500 beds	620 pounds
" II	300-500 "	550 "
" III	200-300 "	510 "
" IV	100-200 "	450 "
" V	50-100 "	370 "
" VI	20- 50 "	320 "
" VII	under 20 "	300 "
First Assistant-Matrons (according to number of beds)—from		300-420 pounds
Second Assistant-Matrons and *Home Sisters*—from		290-350 "
Supervising Sisters—Ward Sisters' rates plus		20 pounds
Tutor Sisters (Instructors) Class I		350 "
Others with post-graduate qualification—Ward Sisters' rates plus		20 "
Others without post-graduate qualification—Ward Sisters' rates plus		10 "
Night Sisters (permanent night duty—over 12 months)—Ward Sisters' rates plus		50 "
(temporary—under 12 months)—Ward Sisters' rates plus		30 "
Theatre Staffs (Operating Room)		
Supervising Sisters—Ward Sisters' rates plus		20 "
Other Sisters — " " " "		10 "
Staff Nurses —Staff Nurse rates "		10 "
Sisters in Special Department		
First Year —Ward Sisters' rates plus		180 "
Second Year— " " "		200 "
Third Year — " " " "		220 "
Fourth Year— " " " "		240 "
Fifth Year — " " " "		260 "
Sixth Year — " " " "		270 "

twenty pounds is added to salary if sister is in charge of a special department, or if lectures are given in connection with the special type of work. In addition to all of the rates, full board, lodging, and uniforms shall be provided. Living-out allowance to be determined by each hospital board according to the circumstances in each locality, but in no case more than a hundred pounds per annum.

Annual leave of four weeks on full pay is provided for all registered nurses, with one week on full pay additional given to Sister Tutors at the end of first term. Sick leave includes four weeks on full pay and four weeks on half-pay after four years' service, in any one year.

From the foregoing it is evident that this whole matter of personnel policies and practices is of utmost importance to national and international nursing associations. The nurses of Canada will, no doubt, watch with the keenest of interest the development of policies similar to that of New Zealand and perhaps before long we, too, may have a national plan.

Great Britain

The editor of the *Nursing Mirror* urges research in nursing to be undertaken, to investigate what is needed by the nurse in her place in the nursing team and in hospital conditions. She wisely suggests that the committee of inquiry should be reinforced by able persons from outside (educational or business) who can bring a detached mind to bear on the nursing problem. The editor goes on to state that this committee of inquiry should be a strong team which would combine the most progressive nursing and medical brains, the best in education and a sympathetic expert with wide experience of business successes and failures.

We have been reading with interest the reconstruction and reorganization of the whole hospital field that is being undertaken in England under Mr. Bevan, Minister of Health, and it seems timely that the series of articles entitled "Reconsideration of Nursing—its Fundamentals, Purpose and Place in the Community", by two well-known writers, G. B. Carter, B.Sc. (Econ.), S.R.N., S.C.M., and Evelyn C. Pearce, S.R.N., R.F.N., S.C.M., should appear at this particular time.

These writers bring out the necessity of considering the whole matter of nursing from the point of view of the patient. The scope of the nurse's work must be very clearly understood in order that the best use of her skills and her personality can be made. These writers state that a thorough job-analysis of the work of nurses may well show that professional nursing is likely to progress along three main roads:

(a) One will attract to nursing a woman whose chief interest is cure and rehabilitation;

(b) a second leads to the public health and community fields and should appeal to those who are interested in the social services;

(c) a third will draw those who enjoy the technical aspects of nursing.

The nurse stands in an intimate personal relationship to her patient unlike that of any other member of the health team. From the point of view of training, we badly need the unifying idea that three-quarters of the nursing care of sick persons, whether they are classed as surgical, medical, mental, or fever cases, is common to them all.

Reduction in hours of ward work, assuring student instead of employee status to candidates, and longer holidays for everyone are recommendations made for radical reconstruction of schools of nursing in Great Britain.

The demand for nursing service is likely to increase for the following reasons:

1. A new conception of preventive medicine for early diagnosis and treatment will bring patients into hospital earlier than is the case at present.
2. Greater demand for hospitalization for obstetrical patients.
3. Adequate care of the chronically ill.
4. Suitable provision for the old.

These two authors mention the central, preliminary schools of nursing, and state that these should be provided by the education authority serving a region rather than individual hospitals. These central schools, however, are for preliminary students only.

We await with interest the next instalment of this series.

A Satisfactory Conclusion

HAVE YOU EVER WONDERED what the end result will be in some of the interesting cases which are reported from time to time in the *Journal?* It is not always possible to bring our readers the final chapter but, happily, we have received word of one such conclusion.

An article "An Interesting Surgical Case," by Dorothy Thomas, was published on page 455 in the June, 1945, issue. In this article, Miss Thomas described how "The upper end of the common duct was opened and a No. 18 catheter was inserted into the duct up through the left hepatic duct to the liver and sutured with No. 0 catgut, the other end implanted in the stomach wall for a distance of 5 cm. down to the mucous membrane." This operation took place in September, 1944.

Now the final paragraph can be written. Miss Thomas has written to say that on January 15, 1946, the rubber catheter was expelled by rectum. Mrs. S. has gained in weight and is in excellent health.

STUDENT NURSES PAGE

Acute Peritonitis

MARIAN EDY

Student Nurse

School of Nursing, St. Paul's Hospital, Vancouver, B.C.

THERE ARE FIVE CHILDREN in the White family. Beverly is six. Mr. and Mrs. White appear to be sensible, well-adjusted people of moderate circumstances. Beverly does very well in school and is in grade one. He takes a lot of pleasure out of doing his "homework" in the evening or listening to the radio while he does his crayoning. Beverly is neat and apparently has good health habits and good food, because of his clear complexion, bright eyes, shining dark brown hair, and excellent teeth.

Mrs. White said Beverly was seldom sick, until a few days before he was brought to the hospital. One night he complained of abdominal pain before going to bed, but he slept fairly well, so went to school the next morning. The teacher sent him home about 10:30 a.m. because of a vomiting spell. About 8 p.m. that night he complained of acute abdominal pain. For the next two days he ate almost nothing and stayed in bed, his mother thinking it was just a "stomach upset". But on June 11, when he seemed to be much worse and was looking very ill, Dr. E. was called. Beverly was sent to the hospital that same afternoon.

Bev. was a very sick little boy when he arrived. He was brought up to the department in a wheel-chair, bent almost double, eyes swimming, with a very pale, anxious face. His temperature was 101°, his pulse rapid. He was put to bed, where he lay quietly with his knees drawn up to his abdomen with pain.

Dr. E. ordered sulphathiazole tablets gr. 15 stat, then every four hours, gr. 7½. Beverly could not retain the drug for the first dose, so it was repeated and this time retained. Sulphathiazole was ordered because the high temperature indicated the body's resistance to infection. The action of sulpha. is bacteriostatic, that is, it inhibits the growth of bacteria, giving the white cells a chance to multiply and build up antibodies against the disease. The drug is given every four hours because it is excreted quickly through the urine. Excretion output is assured by means of an intravenous if the patient is not able to take fluids by mouth when sulpha. is being given. A complication of kidney damage might occur if the drug were allowed to crystallize in the kidney due to decreased output. So, 500 cc. of normal saline and 10 per cent glucose was ordered. This would also help to counteract the lack of nourishment for the past few days.

Beverly's abdomen was rigid and distended, so hot fomentations were commenced. These are used because: (1) they relieve pain; (2) they localize the infection by increasing the blood supply, thus bringing more and more of the body defence agents into the field of action; (3) they relieve rigidity to some extent.

Beverly had frequent liquid bowel movements. Because of the severe pain, he was given codeine grains ½ by hypodermic at 1 a.m. He slept for short periods. His temperature at 12 p.m. was 100°. He was put into Fowler's position which aids in the relative relaxation of abdominal muscles. The purulent fluid tends to gravitate to the lower part of the peritoneal cavity.

The next day Beverly looked tired and pale. His face was flushed, with bright red spots on both cheeks. His skin was hot and dry. Respirations were rapid, 58; pulse was regular, 144; temperature, 100°. His eyes did not appear to focus correctly at times. He lay very quietly and resented being awakened so often to have foments changed. Being unable to retain anything taken by mouth, he was given sulphathiazole intravenously instead of in tablet form.

Penicillin was then started—15,000 units intramuscularly every three hours. Dr. E. made a tentative diagnosis that Beverly's trouble was peritonitis and assumed it to be caused by staphylococcus, but as yet had no definite proof. Penicillin is bacteriostatic and also a bacteriocide, that is, it kills the organism. Penicillin is excreted from the system at the end of three hours, so it is necessary to give it regularly.

A gastric suction tube was inserted through Beverly's nostril. Gastric suction is a method of removing the stomach contents which may accumulate due to irritation of the intestines and in most cases it relieves nausea and vomiting. This was used for Bev. because of his nausea and distended abdomen. The gastric suction returned brown liquid with green particles and frothy mucus.

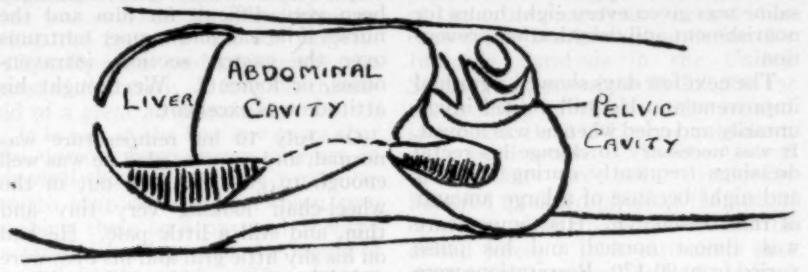
On June 13, Bev.'s temperature was down to 99°, likely due to the effects of the sulpha. and penicillin. But he was listless, voided involuntarily, continually threw his covers off, and was troubled with vomiting. Emesis was a greenish colour with a fecal odour. His dry cough was troublesome at times and he expectorated thick phlegm. Foments, gastric suction, penicillin, and sulphathiazole were continued as before.

From June 14 to 16 Beverly improved a little each day. His abdomen was becoming softer and less tender, although it was still somewhat distended. A greenish-coloured fluid was being expelled through the gastric suction. He was restless, but made no complaints of pain. He was better able to retain fruit juices. Treatments were continued as before. A blood transfusion of 250 cc. was given. His red blood count was 3,190,000 red blood cells per cm. This increased to 3,380,000 two days after the transfusion, but was still low as compared to the normal. Beverly's white cell count on June 11 was 36,750 per cm. and on June 15 was down to 14,600 per cm. This was an amazing decrease in such a short time and it was probably due to the administration of penicillin. A very high W.B.C. indicates a great resistance of the body to infection and when it comes closer to the normal (5,000-10,000 per cm. of blood) we realize the infection is more nearly under control.

From June 17 to 22 Beverly showed great improvement. His abdomen was soft, no tenderness, but it was still slightly distended. All his treatments and medications were discontinued because his temperature was back to normal and his urinalysis and blood tests were also close to normal. He played happily and was very hungry, so was put on a soft diet of cream of wheat, soup, milk, jelly, and ice cream. He tolerated them well.

Every morning he was given a mayo enema. This is to make sure of evacuation and rid him of the poisons accumulating from the infection. The results of the enema are usually small, due to such a small diet. Another transfusion of 250 cc. of blood was given in an attempt to bring his red blood count right up to normal and thus increase his strength and rate of recovery.

At last, on June 22 he was allowed up in a wheel-chair. This caused great delight, but he looked so pale and thin. That evening he began complaining of pain when voiding. This trouble increased until he cried when voiding the frequent small



Incorrect position—poor abdominal drainage

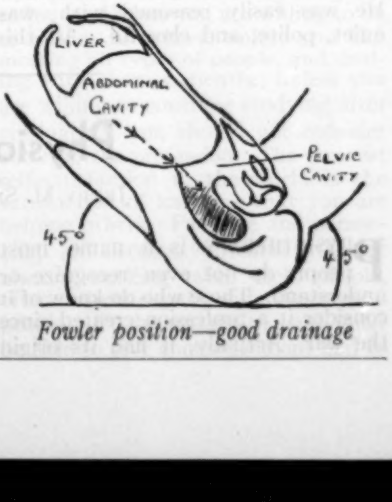
amounts. Catheter specimens were taken and sent to the laboratory. They showed a faint trace of albumin, which was normal, a reaction of 6.5, normal being 7, and a specific gravity of 1.016, which was also normal.

During the next four days, from June 22 to 26, his abdomen became distended again, rigid, and very painful. Gastric suction was again commenced and a large amount of gas and undigested food was expelled. Hot fomentations were renewed. He was unable to retain fluids, so was given sulphathiazole gr. 7½ intravenously every eight hours as his temperature rose; 500 cc. of normal saline and 5 per cent glucose were given twice a day for dehydration and nourishment. He still voided involuntarily. He slept fairly well at night, but usually awoke feeling miserable and depressed. He became very listless, unresponsive, and dozed long periods.

On June 26 he had an attack of projectile vomiting. The emesis contained numerous flecks of bright red blood, clots, and a large amount of what appeared to be well-formed fecal matter. The mayo enemas were returned almost clear. It appeared that there was intestinal obstruction. A rectal examination was made and Beverly was booked for emergency surgery.

In the surgery, blunt-ended forceps were inserted through the anus to the anterior wall of the rectum. Here a large obstruction was found. The forceps were forced through the abscess and large quantities of thick pus, streaked with blood, poured out through the anus. The doctor expressed as much as possible, left the abscess open to drain further, and applied sterile dressings. A specimen of the discharge was sent to the laboratory. Results showed that it contained *Staphylococcus albus* and *B. coli.* The infection from the ruptured appendix was responsible for the escape of the *B. coli* through the intestinal wall. Penicillin would not affect *B. coli*, but would attack the gram positive *Staphylococcus albus.*

When Beverly returned from surgery he was semi-conscious and his pulse was 120. He was soon conscious and condition was good. He dozed for short periods and seemed to have a more relaxed expression. He was placed in Fowler's position again to assist drainage. Gastric suction was reinstated because of abdominal distention; greenish fluid returned. Solu-sulphathiazole gr. 7½ was given every eight hours. Intravenous of



Fowler position—good drainage

500 cc. glucose 10 per cent and normal saline was given every eight hours for nourishment and dehydration prevention.

The next few days showed a gradual improvement. He still voided involuntarily and cried when he was moved. It was necessary to change his rectal dressings frequently during the day and night because of a large amount of thick discharge. His temperature was almost normal and his pulse varied from 90-120. Respirations were normal. He was gradually able to tolerate fluids and his sulpha. drug was discontinued.

On June 29 Bev. was able to sit upright in bed, was very hungry, and played quietly. He was allowed a soft diet. The soap-suds enema was returned highly coloured, with particles of stool. All his medications were discontinued and he seemed to be regaining his strength gradually. He had two or three bowel movements a day of light brown stool, so we knew his intestines were almost back to normal again.

It was a great day on July 5 when Beverly was again allowed up in a wheel-chair. He looked so tremendously pleased with himself and grinned so sheepishly you couldn't help but laugh. Dr. E. decided to allow him to go home. Bev. talked to the nurses and internes and decided that he would like to "live" in the hospital all the time with them.

Beverly was a good patient. We could easily see that he was used to discipline at home because he was usually so co-operative in taking his treatments and doing as he was asked. He was easily reasoned with, was quiet, polite, and cheerful. All this helped his recovery, for it would have been very difficult for him and the nurses if he had had temper tantrums over the gastric suction, intravenouses, or foments. We thought his attitude was excellent.

On July 10 his temperature was normal, and we were glad he was well enough to go. He rode out in the wheel-chair looking very tiny and thin, and still a little pale. He had on his shy little grin and his eyes were as bright as stars as he said good-bye.

All this trouble might have been prevented had Mrs. White recognized Beverly's "stomach upset" as an appendix attack. She would have 'phoned the doctor immediately and he would very likely have removed the appendix on arrival at the hospital. Thus there would not have been as much chance of the appendix rupturing and Bev. would have been home in about ten days.

In some cases if the doctor knows definitely that an appendix has ruptured and can get the patient to surgery within twelve hours, he can suction off the discharge, suture up the appendix, and pour in sulpha. powder to prevent infection. He could then give sulphathiazole by mouth and the patient would likely recover almost as quickly as if it were an ordinary appendectomy. But Dr. E. was not able to tell exactly when Beverly's appendix had ruptured, so could not carry out that procedure for Beverly already had all the symptoms of peritonitis. In Bev.'s case he might not have fared so well had it not been for the almost immediate diagnosis of acute peritonitis and the necessary treatments carried out accordingly.

Physiotherapy

JERRY M. SMITHWICK, B.A.

PHYSIOTHERAPY is a name most people do not even recognize or understand. Those who do know of it consider it a profession created since the war. Actually, it had its origin as far back as Hippocrates in 500 B. C. The Egyptians, Greeks and Romans made use of many features of physiotherapy. In World War I it had its greatest impetus. It has gained new heights in World War II. Many claim this war will do for physiotherapy what the last war did for surgery. It is really a new profession in the true sense of the word. It is at the threshold of a great advancement.

It is just in the last few years that the doctors have shown interest in physical therapy. It is only very recently that doctors have been prescribing their own physical therapy instead of leaving it in the hands of the physiotherapist. The doctors returning from overseas show a great interest in the possibilities of the profession. They have learned of its true value and are anxious to introduce it into their civilian practice.

Physiotherapy is defined as: The treatment of disease by non-medical means, comprising the use of massage, exercise, and physical, chemical, and other properties of heat, light, water, electricity (except roentgen rays, radium, and electrosurgery).[1]

The physiotherapist is a highly trained technician. She is a specialist in giving massage, electrotherapy, light, heat, hydrotherapy, and corrective exercises.

Physical therapy has proved a necessary adjunct to medical and surgical treatment in rehabilitation of injured persons. Physical therapy should be prescribed by a physician and administered by a trained physical therapy technician under medical supervision.

There is an acute shortage of qualified physical therapists in Canada. Hospitals all over the country are advertising for them in vain. The profession has made such progress that it is impossible for the supply to meet the demand. There are a number of reasons for this. A large number of technicians were called into the armed services. The rehabilitation program as set up in Canada will and has required large numbers of technicians. In addition to this, there is a marked increase in civilian hospitals for industrial workers, post-operative cases, and crippled children.

Poliomyelitis is requiring a large number of physiotherapists in its treatment each year. The critical shortage of qualified physical therapists which endangers the proper care of infantile paralysis victims has caused the National Foundation for Infantile Paralysis in the United States to appropriate $1,267,600 for the training of these vitally needed specialists, Basil O'Connor, president, announced recently.[2] In the United States there are only twenty-five hundred qualified physical therapists, of whom more than half are in the armed forces. It is estimated that twice the number already trained could be used for infantile paralysis alone.

In Canada, physiotherapy has been done, for the most part, by unqualified people with very little and, sometimes, no knowledge of anatomy, physiology, pathology, physics, or other of the rudimentary sciences necessary for the proper use of the modalities of physiotherapy. They have been diagnosing their own patients and have not been under the supervision of the medical profession. This has led to false impressions. Attractive, different, and often spectacular forms of treatment were presented. This led to quackery and distrust in the eyes of the public. This, more than any other factor, held physical therapy in the background. Not until more people with the proper character and aspirations are willing to take the education and training necessary to become qualified physiotherapists will the profession reach its true eminence.

The basic qualification to enter the profession, or any profession, is education. This is essential, but equally important is the character and aspiration of the individual considering entering it. Unless you are willing to be of service to others; unless you like meeting all types of people, and dealing with them patiently; unless you are willing to continue studying after graduation, you should not consider entering the profession. The greatest self-satisfaction in the world is the satisfaction of knowing that you are helping others. Patience and personality are necessary because you are always working with sick people, often discouraged and dissatisfied people. To be successful, you must be able to give encouragement and to stimulate the patient with new interest. Physiotherapy is a changing profession. Scientific research is continually offering new ideas. The successful physiotherapist is the one who is willing to study and keep abreast of the new ideas. The last essential qualification is the desire to work with your hands. The ancient idea that a girl must be of a large stature, or must have certain shaped hands, has been disproven. "Rubbing by a husky bath attendant has no relation to scientific massage and the effectiveness of the treatment depends by no means on the amount of physical effort expended."[3]

The nursing profession is the most likely and best source to fulfil the need. They have already shown themselves to be of the right temperament. Their basic training in nursing is an excellent adjunct.

In Canada there are two schools of Physical Therapy—Toronto University, Toronto, and McGill University, Montreal. Both give two-year courses. Graduation from high school is the prerequisite. Further information could be received by writing either of these colleges, or to the Canadian Physiotherapy Association, 184 College Street, Toronto 5.

Numerous American universities give courses approved by the American Physiotherapy Association, and by the Council on Medical Education and Hospitals of the American Medical Association. Candidates for admission should be able to satisfy one of the following requirements: (a) Graduation from an accredited school of nursing; (b) graduation from an accredited school of physical education; (c) two years of university, with science courses.

Other schools require three years of university with science courses, and still others require only high school graduation but a longer course is then given. The courses vary in length. The average is either nine or twelve months. Further information can be received by writing to the American Physiotherapy Association, 1790 Broadway, Room 505, New York City 19.

It is most essential that you choose a college approved by the American Physiotherapy Association. Do not choose a sub-standard course.

In the March 27, 1937, issue of the *Journal* of the American Medical Association, it was stated: "The public is gradually learning what to expect of hospitals. The best that is known in medical skills, technical aid, and personal comfort, should be available in every institution that calls itself a hospital. These are just a few of the many factors contributing to the very urgent need for physical therapists. Physiotherapy is an essential service which every hospital should provide. However, opportunity to provide this service will be lost unless personnel can be trained to fill the need."[4]

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Kitchen Sanitation

Every hospital has an enormous number of dishes to wash in the course of twenty-four hours. Not all hospitals are fortunate enough to own dish-washing machines. The following instructions, recommended by the California Department of Public Health in their recent *Bulletin*, may well be studied by any hospital using manual dish-washing techniques. These are minimum standards. Additional safeguards may be required by local health departments:

HOW TO WASH DISHES

A two-compartment sink, a sink and a dishpan, or two large dishpans are needed.

Scrape the dishes and utensils carefully to

remove particles of food. It is desirable to rinse dishes before washing.

Wash dishes thoroughly in **hot** water with enough soap or detergent to make good suds so as to remove all grease and food particles. Water should be as hot as the hands can stand (110° -120°F.). Change water frequently to keep it clean and always hot. Take particular care in washing tines of forks and bowls of spoons. Thorough washing and rinsing of dishes and utensils is very important in order to prevent the growth of germs and moulds.

HOW TO SANITIZE WASHED DISHES

Simple washing and rinsing of dishes is not sufficient to guard against the spread of disease when dishes are used in group feeding. For this reason, the dishes, utensils, and food containers used should be sanitized. This can be done by one of the following methods:

Method 1. Place washed dishes and silver in a wire or wooden rack and immerse them for at least two minutes in clean hot water, at or near the boiling point (170°F. or higher).

Method 2. First rinse the washed dishes and utensils of soap. Immerse for two minutes or longer in lukewarm or cool water to which chlorine has been added in the proportion of 100 parts per million. As more dishes are immersed, more chlorine should be added. The use of racks for lowering the dishes into the solution will be found convenient. One tablespoon of a 3 per cent solution of chlorine to one gallon of water will give a solution of the desired strength. Chlorine preparations vary in strength. Consult your local health office if in doubt as to the amount of any given commercial preparation you should use.

Method 1 is preferred because it is simpler and because it is easier to control the temperature of water than to control the amount of chlorine which evaporates.

HOW TO DRY DISHES

The best method is to leave the dishes and utensils in the racks and drain and dry in the air. Cover with a clean cloth. Drying of dishes and utensils with towels is not recommended, but if done towels shall be clean and used for no other purpose.

HOW TO STORE DISHES

When dishes and utensils have dried they should be put away in a clean, dry, closed cupboard. Glasses, bowls, and cups should be inverted. Silverware should be placed in a covered box or drawer.

Care should be taken to handle the clean dishes and utensils as little as possible. Glasses and bowls should be grasped from the bottom, plates at the edge, cups by the handles, silverware by the handles, etc.

HOW TO DISPOSE OF GARBAGE

Arrange for removal of garbage at least twice a week or dispose of it by burying it immediately and covering it with at least six inches of packed earth, or burn it in an incinerator. Until removal, garbage should be kept in a metal container closed with a tight lid. These containers must be cleaned thoroughly after each emptying. Do not allow garbage to accumulate.

HOW TO DISPOSE OF DISHWATER

Institutions which have a connection with a city sewer system or with a septic tank or cesspool should flush the dishwater into that system. Institutions having no connection with a waterflushed drainage system should make provision for sanitary underground disposal of dishwater. Advice concerning the construction of such disposal systems can be obtained from local health departments.

Snacks

Nourishing in-between-meal snacks are beneficial to industrial workers. Such snacks result in less fatigue due to monotony and routine, and more energy and improved health and efficiency.

The best time for a light snack is about an hour and a half before lunch and about two hours after lunch. It is stated, however, that the size of the snack and the time it is eaten depends on hours of work at the plant, the type of labour involved, and the kind of meals eaten at home.

For tasty sandwich fillings, made with whole-wheat bread, lettuce and salad dressing, the following are advocated: (1) cottage cheese, grated raw carrot, chopped green peppers; (2) flaked and boned canned salmon, and green peas; (3) shredded cabbage, chopped parsley, and hard-cooked eggs, minced; (4) cold meat, chopped and diced celery; (5) shredded spinach, ground liver, chopped sweet pickle.

—*Health News Service.*

Letters from Near and Far

At the El Shatt UNRRA Camp

It is a long time since I received your letter asking me to write about some of my experiences, and it is only now that I am getting around to it. I think I shall give you a full account of the months I spent in a Refugee Camp in Egypt, for this was undoubtedly one of my most interesting experiences. Sometime later I shall write you something about life here in Greece.

From December, 1944, to April, 1945, I was stationed at El Shatt Refugee Camp, which is about one-half hour's drive from the city of Suez. At this time there were approximately twenty-six thousand Yugoslav refugees in the camp. Most of them were from the Dalmatian coast area and had been evacuated to Italy, only to be sent on from there by the Army as military operations made it impossible for them to remain in Italy.

This camp and several other refugee camps had been established by the British military authorities, which were subsequently taken over by MERRA (Middle East Relief Association) and later, in the spring of 1944, by UNRRA. Many of the British military officers remained in office after UNRRA took over the administration of the camps. In fact, it was not until April, 1945, that the administration came completely under UNRRA civilian personnel.

Mary Henderson at Camp 6, El Shatt

There were really six camps comprising El Shatt Camp, all within easy driving distance of one another. There was a central Headquarters Administrative Office and in addition each camp had its own Administrative Office with a staff consisting of a commanding officer, with British Army and UNRRA personnel doing administrative, health and welfare work.

The refugees themselves also had a central committee and a camp committee for each camp. The Yugoslavs are an independent people and showed a sincere desire to manage their own affairs. The great majority of the refugees were women and children, and of the men in the camp most of them were middle-aged or older.

The living quarters for the refugees were large tents housing about twenty to twenty-four people, with usually ten to twelve cots lined up on each side of the tent. Often four or five families occupied one tent and it was remarkable that they all got on so well together considering they lived in such close proximity. Some of the tents were fixed up quite attractively, with hand-made benches outside, and a few little green shoots planted in the sand around the tent door.

There were bath houses, open-air ablution benches, and latrines for each camp. There were also camp kitchens with dining-tents attached, but although the rules of the camps were that all refugees should eat their meals in the dining-tents, most of them preferred to take their food to their own tents. There was ample food for the refugees, but there were complaints about the monotony and the manner of cooking the food. The cooks and other workers in the kitchens were all Yugoslavs. There was one UNRRA dietitian supervising the diets in the camps who did all she could to improve the fare of the refugees.

The various workshops in the camps were most interesting. Among them were carpentry, tinsmithy, tailoring, sewing, shoemaking, and art workshops. Here the Yugoslavs worked mostly with hand-made tools and the things they fashioned with these simple tools were remarkable.

There were also medical inspection and baby bathing tents, about which I shall say more later. Perhaps, at this point, you can visualize the camp as a little world of its own set in the middle of the desert.

The staff had their own living quarters. We lived in tents, the women in a separate section protected by a seven-foot matting fence and called the "Women's compound." We slept on army cots and used oil lanterns, and outdoor shower house and latrines. It was quite an experience living in a tent during the winter months and although usually the days were bright and sunny, the nights at this time of year were very cold. But, in spite of our primitive living conditions, most of us enjoyed our experience very much.

For my first month at El Shatt I worked in the 400-bed hospital serving the camp and was glad of this opportunity to learn the hospital routine. Some of the hospital wards were in small, one-storeyed wooden buildings, while others were in tents. There were separate wards for women, men, children, and for maternity cases, tuberculosis, and other infectious diseases. Nursing care, as we know it in our modern hospitals, was not given here, but the best care possible with an inadequate number of trained personnel and inadequate equipment and drugs was attempted. The problems were many, such as, for example, taking temperatures on a 50-bed ward with two thermometers, or giving out medications in four egg cups to twenty or more patients.

The most interesting feature of the hospital to me, was the training of the young Yugoslav girls as nurses' aides or *bolnicarke* as they were called in Yugoslav. These girls were carefully chosen and were given a six-week basic course in nursing procedures, followed by three weeks in medicines and three weeks in maternity. One of the UNRRA nurses was in charge of the teaching program and the UNRRA nurses working in the hospital supervised the *bolnicarke* on the wards. As you might imagine, there were many difficult and amusing situations as a result of our limited knowledge of the Yugoslav language, but we usually managed to make our meaning clear with a great deal of hand motioning and the odd Yugoslav word. These young nurses' aides learned to give good elementary nursing care and often had to assume a good deal of responsibility. Their training was given not only with the thought of them working in the camp hospital, but also with the intent of their being able to give useful service on return to their own country.

Refugees

During the month of December, when I was working in the hospital, there were many cases of pneumonia and rheumatism. The fact that the refugees were living in tents, in a climate with extreme changes in temperatures, may have been a contributing factor to this high incidence of pneumonia and rheumatism. I did not see any marked nutritional deficiencies, for by this time such deficiencies had been corrected as a result of the regular and adequate feeding they had received since coming to the camp.

Following my brief period in the hospital I supervised the public health nursing program in the camps. When the camp was first established there was an insufficient number of nurses for the hospital, and no nurses at all available for service in the camps. But in the late fall of '44, when more UNRRA nurses arrived for duty in the camps, it was possible to start a public health nursing service. The public health nurses worked in close co-operation with the doctors in the medical inspection tents in each camp. These M.I. tents worked like out-patient departments of hospitals. Here the doctors examined all ailing refugees and, when necessary, the patients returned regularly to the M.I. tent for treatment or were admitted to the hospital.

There was also a baby bathing tent with facilities for the mothers to bathe their babies in warm water. Here the public health nurse was able to accomplish a good deal of teaching. Mothers brought babies with non-infectious skin conditions regularly for inspection and treatment. Bathing of baby and preparation of feedings, etc., were demonstrated to the mothers. Health posters were on display in the tent. Weekly baby and pre-natal clinics were held with a doctor in attendance and

At the train, waiting to leave for home

follow-up conferences and tent visits were carried out by the nurses. Every day dried milk was prepared and distributed for babies under two years and for pregnant and lactating women. Young Yugoslav girls worked in the M.I., baby bathing, and milk distribution tents under the supervision of the public health nurse. These young girls also carried on regular tent visiting for which they were given a short well-planned course conducted by a Yugoslav doctor and sanitation expert. Following completion of their course, they worked under the supervision of the public health nurses. Their duties consisted of visiting the living quarters, dining-tents, kitchens and latrines; to see any sick people, inspect the sanitary conditions and report any abnormalities. All patients discharged from the hospital were followed up by the tent visitors. They carried out their duties for the most part very efficiently and would undoubtedly be useful workers on their return to their own country. The public health nurses endeavoured to teach these tent visitors and other camp workers as much as possible. Examination of school children and establishment of nursery schools were started in some of the camps. Scabies was quite prevalent and scabies treatment clinics were commenced. Immunization clinics were held periodically. The gratifying part of the public health work in the camps was that we could see some results as, for example, a decrease in the number of admissions to hospitals, especially among the babies and children. On the whole, the Yugoslavs seemed to appreciate these health services and responded well to them.

I should tell you something now about our surroundings and social life. As I have said, most of the refugees came from the Dalmatian coast area which is famous for its beauty, and after the vista of mountains, trees, and sea they were used to, it must have been very hard for them to adjust to life on these barren desert sands. However, the desert, too, has a beauty of its own which struck one forcibly at times—especially as you gazed at a beautiful desert sunset. From the site of El Shatt Camp, we could see the distant, bare hills of Attica. The Suez Canal was within ten minutes walking distance. This was a favourite walk of the refugees and the bank of the canal was a chosen spot for meditation. Every effort was made to make the life of the refugee as nearly normal as possible, and with this in mind activities were planned in all the camps. There were recreation centres, churches, schools, police force, playground, youth clubs, languages classes, etc. Various entertainments were held at which groups danced their native dances and choirs sang their native songs. The refugees were not allowed to cross the Suez Canal without special permission from the H.Q. Administrative staff. Frequently groups of the young Yugoslav nurses' aides were escorted by UNRRA nurses to dances at British Army messes in the area, and it was very good to see these young girls enjoying themselves. Difference in language didn't prove to be a great barrier.

Our staff included a mixed group of nationalities—American, English, Canadian, Palestinian, Czechoslovakian, Yugoslav, etc. Living and working with so many nationalities was an education in itself. The social life for the women members of the staff could be very arduous as there were many Army messes in the area and invitations to dances and entertainments were numerous. Usually everyone managed to spend a week-end in Cairo once a month where they could stay at a hotel and enjoy the comforts of civilized life, especially the hot baths, plumbing, and electric lights. Cairo was an exciting and interesting city to visit, but although we looked forward to week-ends there, we were usually glad to get back to life on the quiet desert.

Egypt seemed such a land of contrasts with its warm, sunny days and cold nights; its teeming, dirty, noisy cities, and quiet, clean desert lands; its evidences of great wealth and extreme poverty. Civilization hardly seemed to have touched some of the rural areas. The country scenes reminded me of the Biblical pictures I used to get at Sunday School as a child—the palm trees, the donkeys and camels, yokes of oxen plowing the fields, the women dressed in long, black robes carrying earthenware jugs on their heads, the men in long, white, flowing robes. Life in this desert camp was certainly an adventure and, although at times it was trying, it was for the most part an exciting and novel experience. One of the reasons we enjoyed our experience as much as we did was due to the fact that we had a great regard for the simple, industrious Yugoslav peasants and grew very fond of them. I have many happy memories of El Shatt days and I am sure my months there will always remain one of the highlights of my life.

—Mary E. Henderson

From a C.G.H. in Germany

Strangely enough, although the war is over and we have no more war casualties, we are kept busy with road accidents and winter ailments.

This is a very happy unit. The hospital is very modern and is a former naval establishment so we are most comfortably quartered. We now have quite a few German naval orderlies, who are mostly excellent workers. I think this has been found necessary because so many of our own boys have been repatriated.

The countryside here is very uninteresting and is the same from Hamburg to the Dutch border. We are able occasionally to go south to the Hartz Mountains where there is a leave centre for short leaves. The skiing is good and the mountains such a pleasant relief from the monotony of this part of the land.

The devastation in Wilhelmshaven, Bremen, Hamburg, and Hanover has to be seen to be believed. These are the only cities I have seen but I understand the others are similar.

The Germans in this area are not particularly friendly. We are an hour's drive from Oldenburg which was declared an open city. It is the first time in its history the town has fallen to an enemy so they are naturally very cold. There is quite a marked difference in the people farther south. I think all are relieved they are not in the Russian zone. I think it would be interesting if we could meet some Russians but there seems to be no opportunity.

—Lieut. (N/S) Maisi Gordon

(*Royal Victoria Hospital, Montreal, 1942*)

Never did I think my first Christmas of the peace would I be in Germany. We all had a very happy one here and although many of us were disappointed at not being home, we made the best of it. We had heaps of supplies of all the Christmas extras for everyone and simply delicious turkey. The hospital, which is a huge place, looked lovely. Patients, staff, and German civilian help, of which we have a large number, all entered into the spirit early and did wonders with what decorations we were able to get. Christmas Eve we sang carols through the corridors accompanied by a German orchestra.

Major (P/M) Constance Winter

(*Royal Victoria Hospital, Montreal, 1927*)

Recently Appointed D. V. A. Matrons

We are very happy to announce the appointment, to D.V.A. hospital positions, of the following R.C.A.M.C. principal matrons recently returned from overseas:

Edna E. Rossiter, R.R.C., a graduate of the Royal Jubilee Hospital, Victoria, B.C., enlisted in the R.C.A.M.C. in 1941. She served as principal matron in M.D. 11 before proceeding overseas as the principal matron of No. 24 C.G.H. She was with that unit in England until she was transferred to Western Europe, to be the principal matron of No. 12 C.G.H. Miss Rossiter returned to Canada in the autumn of 1945 and has been appointed, temporarily, as assistant matron at Shaughnessy Hospital, Vancouver, B.C.

Helen L. Wilson, R.R.C., a graduate of the Winnipeg General Hospital, joined the R.C.A.M.C. in 1942. She went overseas as principal matron of No. 11 C.G.H. Leaving England she was transferred to be principal matron of No. 7 C.G.H., later going to No. 10 C.G.H. She returned to England to No. 17 C.G.H., before her return to

Canada. She has recently been appointed as the matron of Deer Lodge Hospital, Winnipeg, Manitoba.

Doris L. Kent, R.R.C., a graduate of the Toronto Western Hospital, joined the R.C.A.M.C. in 1940, and proceeded overseas as a nursing sister with No. 1 Neurological Hospital. She was with that unit in England and was promoted first to matron, and later principal matron of Basingstoke Neurological and Plastic Surgery Hospital. When this hospital was closed Miss Kent was transferred first to No. 17 C.G.H., and then to No. 2 C.G.H. in Western Europe. Miss Kent returned to Canada in 1945, and has recently been appointed to Christie St. Hospital, Toronto.

Nancy B. Kennedy-Reid, R.R.C., a graduate of the Queen Elizabeth Hospital for Children, London, England, and the Montreal General Hospital, enlisted in the R.C.A.M.C. in 1940. Going overseas with No. 1 C.G.H. as the assistant matron, Miss Kennedy-Reid was promoted to principal matron of No. 1 C.G.H., and went to Italy with that unit in 1943. Later she was recalled to England to become the principal matron of No. 23 C.G.H., and later of No. 24 C.G.H. Recently returned to Canada, she has been appointed as the matron of the hospital at Ste. Anne de Bellevue, Quebec.

RETIREMENTS

Just as we are happy to see new people coming in, we regret losing others—however, so it must be in a world of change.

Charlotte H. Ross, until recently the matron of Christie St. Hospital, held the dual position of administering the nursing service of that very busy hospital, and acting as chief matron for the Department of Veterans Affairs, until the appointment of the present Matron-in-Chief in August, 1945. Miss Ross was the matron of Westminster Hospital, London, from April, 1920, until February, 1937, when she was transferred to Christie St. Hospital, Toronto. We need only mention "Westminster" and "Christie Street" to realize what a busy life Miss Ross has had. To have administered the nursing service of the largest and most active of the D.V.A. hospitals is a professional record few people attain. When Miss Ross retired, the staff presented her with a sapphire and diamond dinner ring, as a token of appreciation. The good wishes of all other D.V.A. nurses are joined with those at Christie Street in the hope that Miss Ross may have good health to allow her to enjoy her well-deserved years of retirement; and that her years may be long and full of contentment.

TRANSFERS

To another of our veteran matrons, *I. M. Barton*, Winnipeg, go our good wishes. For the past twenty years she has been on the staff of Deer Lodge Hospital, and has made a real place for herself in the affection of the staff and patients of that hospital. Miss Barton has been transferred to the position of matron of the Veterans Hospital and Home, Academy Road, Winnipeg. At the same time she will act as the district matron, and devote part of her time to matters concerning nursing at the district administrator's headquarters. At the time of Miss Barton's transfer to her new duties, she was the guest of honour at a tea-party given by the staff, and was presented with a diamond wrist watch by the district and hospital staff in appreciation of her twenty years of service at Deer Lodge Hospital.

T.B. NURSING COURSE

The first twelve nurses to go to the Mountain Sanatorium for the recently organized course in tuberculosis nursing, which Dr. Playfair and Miss Ewart have arranged for D.V.A. nurses, are now almost finished. Key people have been sent in this first group in the hope that they will be able to set up a uniform technique throughout our hospitals. The response among the nurses has been most gratifying, and as time progresses we will report upon this course in greater detail.

—AGNES J. MACLEOD

R. N. A. P. Q. Annual Meeting Dates

The 26th annual meeting of the Registered Nurses Association of the Province of Quebec will be held in the Windsor Hotel, Montreal, on May 16 and 17. An interesting program for both the English and French sections has been arranged. Among other items on the program, Miss Gertrude M. Hall will discuss developments in Placement Service, Miss Margaret E. Kerr will make a brief survey of the future of nursing, and Dr. R. P. Vivian, professor of health and social medicine at McGill University, will address the association the second evening. A symposium on the topic, "Au service du malade" and a showing of health films will form part of the French section program.

Book Reviews

Convulsive Seizures, by Tracy J. Putnam, M.D. 160 pages. Published by J. B. Lippincott Co. Canadian office: Medical Arts Bldg., Montreal 25. 2nd Ed. 1945. Illustrated. Price $2.50.

Designed specifically as a manual for patients, their families and friends, this small volume presents information which should be a part of every nurse's preparation. School nurses will come across numerous children who are subject to seizures, industrial nurses see patients in their working environment, in fact every nurse needs to know more about the topic of convulsive seizures that she may assist in preventing "emotional cripples" resulting from "distrust, condescension and repulsion."

It has been estimated that there are about as many people who are subject to seizures as there are active cases of tuberculosis. There is a close similarity between the social and economic problems which these two conditions may create. However, in the case of convulsive seizures, in many instances "the terrors which attend it are more serious than the disease itself."

Dr. Putnam describes in detail the four main types of seizures—grand mal, petit mal, psychomotor, and Jacksonian seizures. He shows why so much more has been learned about these conditions in the past ten years, since the use of electro-encephalography to trace activity in the brain. He indicates that "the seizures in themselves produce no permanent changes in the patient's appearance or bodily health." He indicates how bystanders can help at the time of an attack. In the first aid measures he recommends putting "a pad consisting of a folded handkerchief or other soft, firm object between the patient's back teeth." How much more sensible than trying to force a *hard* object between clenched jaws, thereby running a risk of breaking or damaging teeth! Regarding the problem of other children witnessing a seizure, Dr. Putnam says, "What children see or hear is not half so damaging to them as the attitude of others present toward the situation. In any moment of stress they alertly watch parents and others to see how the incident affects them. Almost immediately they take over as their own the emotional reaction around them toward any given situation." The onus is therefore on the adult to be calm and to help relieve any tendency to embarrassment.

Treatment under a physician's guidance is discussed, the future outlook for affected individuals and a bibliography for further reading concludes the book.

Principles of Internal Medicine, a Course for Nurses, by D. M. Baltzan, M.D. 398 pages. Published by The Ryerson Press, 299 Queen St. W., Toronto 2B. Price $5.00.

Based on the subject matter included in regular series of lectures to student nurses, this text will prove a valuable addition to the course in internal medicine. Dr. Baltzan has described in considerable detail the causes, symptoms, and significant characteristics of the various disorders associated with the respiratory system, the circulatory system, the blood, the excretory function of the kidneys, the digestive system, the endocrine glands, and psychopathological disorders.

In his introduction, Dr. Baltzan says, "The time has arrived when the nurse should know the diagnosis or the diagnostic difficulties requiring solution in order that she might have more than a servant-like interest in her patient." To accomplish this, he has pointed out with considerable care the different factors which influence the physician in making a more accurate diagnosis of the various disorders, the points of similarity and difference reflected by reported symptoms, etc. Immediate or delayed treatments which may be ordered by the physician are noted briefly. The actual details of nursing care are omitted since they are usually included under the medical nursing course.

Nursing Sisters' Association of Canada

The *Toronto Unit* recently held its twenty-first annual meeting with the president, Mrs Gilbert Storey, in the chair. Eight members attended, including ten nursing sisters of World War II who were warmly welcomed. Miss Heffernan reported sending out fourteen hundred letters and notices and a volume of correspondence during the year. The Blue Cross Hospital Plan has been adopted by this unit, the benefits to be available to all nursing sisters who are members. A memorial to all nursing sisters of both wars, in the form of a clubhouse project, was enthusiastically endorsed. This project will be presented at the biennial meeting which is co-incidental with the C.N.A. general meeting to be held in Toronto, July 1-4. The Toronto Unit is putting forth every effort to entertain the delegates, a dinner being planned to take place at the Royal York Hotel, July 2.

Mrs. Storey was re-elected as president as was Miss Heffernan, corresponding secretary. Two hundred dollars was voted to the War Amputation Fund.

Nursing Sister Ina Pringle, for twenty years on the staff of Christie St. Hospital, has retired, and at a tea in her honour was presented with a purse.

At the recent annual meeting of the *Vancouver Unit* Mrs. A. E. Meeker was re-elected president. Mary McCuaig is vice-president and Mrs. D. Smith is secretary. Many nursing sisters of World War II were present and were given membership in the association for a year. All activities for the past year were a financial success, including the Doll Bazaar and drawing. During the past, donations have been made to the Minesweepers Fund, parcels sent to members' sons who were serving in the armed forces, and the gift box of comforts for veterans at Shaughnessy Hospital was kept well supplied. The garden party, held at the home of Mrs. A. W. Hunter, the Remembrance Day tea honouring the veteran patients of "Hycroft", and several other teas were the social events of the year.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

It is with pleasure that the V.O.N. for Canada announces the appointment of *Hester Lusted* to the National Office staff as Floater. The position of Floater was created recently to enable the Order to have an experienced nurse available to meet emergency needs for a nurse who is capable of assuming considerable responsibility. Miss Lusted, a graduate of the Regina General Hospital and of the course in public health nursing, McGill University, has been with the Order for several years and until recently was nurse-in-charge of the Regina Branch. She has now gone to open a new branch in Port Arthur and will remain there until a permanent appointment can be made.

Phyllis Scouler, formerly a staff nurse on the Regina staff, has been appointed nurse-in-charge of this branch.

Vera Clark has resigned from the Newcastle Branch. *Ruth* (*Sheldon*) *Sellhorn* has resigned from the position of nurse-in-charge of the Edmonton Branch to join her husband. *Edna Dysart* has resigned from the Moncton Branch to be married. *Jeanne*

(Sterne) MacKay has resigned from the Brantford staff to join her husband. *Eileen (Willis) Dill* has resigned from the Winnipeg staff to join her husband.

M. L. I. C. Nursing Service

The following are recent changes in personnel of the Metropolitan Life Insurance Company Nursing Service:

Cecile Leclerc (St. Jean de Dieu Hospital, Gamelin, P.Q.) was recently appointed to the nursing staff in Montreal.

Mrs. Angela (Doyon) Larose (Drs. Normand and Cross Hospital, Three Rivers, P.Q., and University of Montreal public health course) recently resigned from the Company's service. Mrs. Larose was attached to the Quebec City nursing staff. *Alexandrine Gratton* (Notre Dame Hospital, Montreal) has submitted her resignation from the Company's service. Miss Gratton was the company nurse in Valleyfield, P.Q., for over five years.

News Notes

BRITISH COLUMBIA

TRAIL:

At a recent meeting of Trail Chapter, R.N.A.B.C., Dr. Bradshaw showed interesting films of the Shriners' Hospital for Crippled Children at Portland, Oregon.

Trail-Tadanac Hospital:

The recent nurses' annual ball was a great success, both from a social and a financial viewpoint. A portable x-ray machine has been added to the hospital equipment.

Recent staff changes include the resignation of Mary Lesuik to go to the Children's Memorial Hospital, Montreal. Additions to the staff include Myrtle Kennettle, Barbara Strickland, Mrs. Elizabeth Strachan, Janet McLennan, H. McKechnie, J. Loughery, and F. Smith.

Vancouver General Hospital:

The annual banquet, given in honour of the 1946 graduating class, was held recently at the Hotel Vancouver. Invited guests present

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included E. Palliser, G. Fairley, E. Paulson, B. Cunliffe, C. Spackman, and Mrs. A. K. Haywood. Unfortunately E. Mallory, A. Wright, E. Braund, and H. Randal were unable to attend. Two hundred and sixty-one nurses were present, including ninety-four members of the graduating class.

An interesting program was enjoyed and a silver casserole was presented to B. Cunliffe by the alumnae members as a retirement gift. G. Fairley, H. Randal, K. Ellis, and E. Johns were made lifetime honourary members.

The invited guests were seated at the head table, with E. McCann, president; Mrs. Bakken, first vice-president; F. Innes, P. Capelle, Mrs. Grundy, O. Robertson, president, Students' Council; B. Gillies, acting president, graduating class; E. Johnstone, L. Holy, Students' Council; Mrs. Joyce Campbell, banquet convener.

VICTORIA:

Royal Jubilee Hospital:

Nora Gladstone, who received her preliminary education at the Blood School operated by the Church of England and who graduated from the School of Nursing of this hospital last year, is one of four Canadian Indian girls who have been accepted by the New Zealand Government Nursing Department for midwifery training. Accompanying Miss Gladstone will be her sister, Doreen, Martha Soonias, and Daisy Horses.

MANITOBA

ST. BONIFACE:

At the recent annual meeting and banquet of the St. Boniface Hospital Alumnae Association the election of officers resulted as follows: honourary president, Rev. Sr. Clermont; president, L. Thompson; vice-presidents, M. Wilson, M. McKenzie; recording secretary, M. Lougheed; corresponding secretary, B. McPherson; treasurer, Mrs. B. Smith; archivist, Mrs. T. Hulme; committee conveners: visiting, D. Hurle; social, Mrs. M. Gendall; membership, B. Sotkowsky; representatives to: M.A.R.N., N. Craig; nurses' directory, E. Gagnon; Local Council of Women, S. Wright; *The Canadian Nurse*, Mrs. H. Lemoine.

NOVA SCOTIA

HALIFAX:

Acting upon a recommendation from the R.N.A.N.S. that each branch devote one of its meetings during the year to the public health section, a recent meeting of the Halifax Branch was conducted by that group, with the convener, Mrs. A. Thorpe, V.O.N., in the chair. Dr. Charles Beckwith, superintendent of the Halifax Tuberculosis Hospital, gave an interesting address on "Tuberculosis Control for Halifax." In his talk he stressed the important part nurses were playing in the control of this disease. At the conclusion, he

REGISTRATION OF NURSES
Province of Ontario

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EXAMINATION ANNOUNCEMENT

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An examination for the Registration of Nurses in the Province of Ontario will be held on May 29, 30, and 31.

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

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answered questions submitted by the members. Kathleen Dickson, supervisor of the city health nurses, extended the vote of thanks. A social hour followed. The nursing education group will have charge of the next meeting.

DARTMOUTH:

Nova Scotia Hospital:

A meeting of the graduate nurses of the Nova Scotia Hospital Training School was held recently, with nurses attending from many parts of the province. The graduates were very enthusiastic concerning the plan to form an alumni association. The result of the election of officers was as follows: president, Eric W. Balcom, N.S. Nursing Home, Wolfville; honourary president, Helen McCauley, N.S.H.; vice-president, Mrs. Anne Drysdale, N.S.H.; secretary, J. Wilfred Landry, N.S.H.; treasurer, Maura Furlong, Infectious Diseases Hospital, Halifax; executive members, Mrs. Edna Doherty, Lyle Skinner, Frank Wambolt.

The Training School of the Nova Scotia Hospital was founded in 1896 and graduates both female and male nurses, many of whom are now scattered across the Dominion and the United States. The president stated that the present addresses of many graduates were unknown and issued an appeal to those who attended the meeting to turn in as many addresses as they know. At the conclusion of the business meeting a social evening was much enjoyed.

ONTARIO

EDITOR'S NOTE: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

DISTRICT 1

CHATHAM:

At a recent well-attended meeting of the Chatham Public General Hospital Alumnae Association Miss Patterson of the V.O.N. was the guest speaker.

DISTRICT 4

At the annual meeting of Hamilton Chapter, District 4, R.N.A.O., the following officers were elected: chairman, Mary Blackwood; vice-chairman, Barbara Keys; secretary-treasurer, Margaret Smith. Sylvia Hallman led a discussion on "Modern Trends in Nursing." Those participating represented the various local fields of nursing.

At a recent well-attended meeting of the Niagara Peninsula Chapter, held at the Welland County Hospital, Dr. S. V. Railton, of Port Colborne, spoke on "War Surgery", relating some of his experiences overseas

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

Placement Service

Information regarding positions for Registered Nurses in the Province of British Columbia may be obtained by writing to:

Elizabeth Braund, R.N., Director
Placement Service
1001 Vancouver Block, Vancouver, B.C.

SPECIAL SCHOLARSHIP AWARD

•

The Alumnae Association of the **Homoeopathic Hospital, Montreal, P.Q.,** is offering a **Scholarship** of **$200** to a member of this Association in good standing, for the purpose of taking a post-graduate course in Teaching and Supervision or Hospital Administration at the McGill School for Graduate Nurses, commencing next autumn.

Those interested and eligible should make application before **May 15, 1946,** to:

MRS. KATHRYN ESSON
Secretary, Alumnae Association,
2132 Northcliffe Ave.,
Montreal 28, P.Q.

during the past five years. Stella Murray was in the chair.

A recent chapter meeting in Fort Erie was visited by the chairman of the District, Ada Scheifele, who addressed the members on the activities of the R.N.A.O.

Hamilton General Hospital:

The Hamilton General Hospital Alumnae Association started the New Year by holding a supper meeting with Ella Baird, the newly-appointed chairman, welcoming the guests who numbered about 125. Arrangements for sending food parcels weekly to the nurses of the Netherlands were undertaken with enthusiasm. Dorothy Voelker contributed to the program by singing two solos accompanied by M. Morgan.

DISTRICT 5

A regular meeting of District 5, R.N.A.O., was held at the University of Toronto. This was one of a series of special lectures and the speaker was Dr. S. K. Jaffary, associate professor of the School of Social Work at the university. The chairman, C. McCorquodale, presided and the meeting was well attended. These meetings on social medicine have aroused great interest and much discussion. The question period was enjoyed and very informative.

DISTRICT 6

At a recent meeting of Chapter C, District 6, R.N.A.O., there were nineteen members present. Reports were given by the hospital and school of nursing and the public health sections. The treasurer's report revealed a balance of $195.38. A $5.00 parcel is to be sent to a Netherlands nurse during the first week of every month. A committee of three was chosen to prepare a brief for presentation to the Town Planning Committee which is in charge of suitable and adequate accommodation for the advancement of culture and handicrafts in the new community centre. The Notes from National Office were summarized by Miss Stewart. Mr. Roy showed slides of the Kawartha Lakes and Mr. Osborne gave a talk on the proposed establishment of a provincial park for Peterborough.

DISTRICT 8

Ottawa General Hospital:

A successful compaign, carried on to arouse greater interest in our National Nursing Journal, resulted in seventy new subscriptions to *The Canadian Nurse.*

Sister George Edmond has been appointed to the staff of St. Vincent's Hospital, Ottawa. Della Carter is now on the staff of the military hospital at Ste. Anne de Bellevue, P.Q. Willa Ahern is now nurse-in-charge of the Metropolitan Nursing Service in Sudbury. B. Legris is night supervisor at the Cornwall General Hospital. M. O'Neill, K. Lincez, and D. Herbert are taking the clinical supervision course in surgery at the University of Ottawa.

QUEBEC

MONTREAL:

Homoeopathic Hospital:

Clara Aitkenhead, instructress of nursing arts, recently spent two weeks at the Winnipeg General and St. Boniface Hospitals observing classroom and clinical teaching. Mabel MacMillan, nursing supervisor, post-operative recovery room and blood bank, has returned from Hartford, Conn., where she spent three weeks observing the technique in the blood bank at Hartford Hospital. Margaret Henderson, head nurse, central supply room, spent two weeks observing the routines in the central supply rooms of the General and Western Hospitals and Hospital for Sick Children, Toronto.

McGill School for Graduate Nurses:

The twenty-fifth anniversary of the McGill School for Graduate Nurses will be celebrated in Montreal on Monday, July 8, 1946, ending with a dinner in the main ballroom of the Ritz-Carlton Hotel. Please watch the *Journal* for further notice.

M. Mathewson, assistant director, has recently returned from an observation tour of the United States, under the auspices of the Kellogg Foundation, in connection with public health nursing. Recent visitors to the School include H. McCauley, L. Sharpe, Louise Bartsch, and Muriel Hunter.

Université de Montréal,
Institut Marguerite d'Youville:

Les infirmières ont répondu, nombreuses aux invitations lancées pour le cours de psychologie et d'orientation professionnelle. Le premier cours enregistra une trentaine d'inscriptions, chiffre qui s'augmenta considérablement aux conférences subséquentes. Une mention spéciale s'adresse à celles qui viennent régulièrement de St. Jean sur Richelieu, augmenter leurs connaissances et se mettre au courant des questions d'actualité scientifique.

Rév. Soeur G. Leduc, s.g.m., poursuit actuellement ses études pour la maîtrise en Education des Infirmières à l'Université de St. Louis, Mo. Elle réintègrera son poste de directrice des infirmières à New Brunswick, N.J., en septembre prochain. Il est à noter que le baccalauréat reçu à l'Institut Marguerite d'Youville a permis à ces aspirantes d'obtenir leur maîtrise dans le minimum de temps consacré à ces études. Isabelle Shooner a accepté le poste d'enseignement aux élèves du cours préliminaire de son alma mater, l'Hôpital Notre-Dame de Montréal. Rév. Soeur Jeanne Forest, s.g.m., après avoir obtenu sa maîtrise en Education des Infirmières, de l'Université Catholique de Washington, est institutrice des infirmières à Calgary.

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About 75 per cent of babies are allergic to one food or another, say authorities. Which agrees and which does not can only be determined by method of trial. In case such allergic symptoms as skin rash, colic, gas, diarrhea, etc., develop, Baby's Own Tablets will be found most effective in quickly freeing baby's delicate digestive tract of irritating accumulations and wastes. These time-proven tablet triturates are gentle — warranted free from narcotics — and over 40 years of use have established their dependability for minor upsets of babyhood.

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SASKATCHEWAN

HUMBOLDT:

Theresa Bevin (St. Elizabeth's Hospital) is now assistant supervisor in the operating-room at the hospital in Watrous. Caroline Dauk (St. Elizabeth's Hospital), who was with No. 2 C.C.S., R.C.A.M.C., for fourteen months, is now back in Humboldt.

MAPLE CREEK:

The Maple Creek Chapter is pleased to welcome Mrs. Patricia Evans, from Medicine Hat, as a member of the chapter.

REGINA:

Grey Nuns' Hospital:

Eight-hour duty has been introduced on the wards for the student nurses. The unit is two weeks; students are on staggered hours for two days, and the alternate two days are on a straight eight-hour shift. Each student has two consecutive days off every two weeks.

New additions to the staff are: Lillian Mallou, children's ward; Bertha Anseth, dressing room; K. Roth, operating-room. B. Hailstone, L. Holstencroft, and C. George, who recently resigned from the staff, are at the hospital in Melville. L. Cranston is on the staff at Fort San.

SASKATOON:

Mrs. G. Harrison, president of the S.R.N.A., is now in residence at the Dominion Experimental Farm.

City Hospital:

The Saskatoon City Hospital Alumnae Association recently held a membership tea.

Mrs. Elda Cameron, science instructor for the past two years, has resigned. Appointments to the staff are as follows: Elda McMahon, second assistant, school of nursing office; Velma Brown, supervisor, first west; Margaret Herschberger, supervisor, fourth east; Margery Gotteler, general nursing staff. Misses McMahon, Brown, and Gotteler were formerly with the armed forces.

WEYBURN:

A handicraft exhibit, belonging to the S.R.N.A., was displayed for the interest of the members of Weyburn Chapter at a recent meeting. At this time it was decided to send food parcels to nurses in Holland.

Some of the nurses from the general and mental hospitals have been taking active part in the local curling bonspiel. Miss M. Young has joined the staff of Weyburn General Hospital.

YORKTON:

Ruth Ganton has resigned her position as obstetrical supervisor at the General Hospital.

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WANTED

Applications are invited for the position of **Provincial District Nurse** in the **Province of Alberta.** Districts located in rural areas; cottage, water and fuel supplied by community. **Salary:** Minimum of $1500 per annum plus Cost of Living Bonus. Sick leave; annual vacation provided after one year's service. Information also provided on other Public Health Nursing opportunities in the Province. Apply to:

Miss Helen G. McArthur, Supt. of Nurses, Dept. of Public Health,
218 Administration Bldg., Edmonton, Alta.

WANTED

Applications are invited for the following positions in a 125-bed General Hospital in **Eastern Ontario: Night Supervisor; Operating Room Supervisor; Ward Supervisor**—35-bed private and semi-private ward.

Apply, stating qualifications, experience, religion, and salary expected, in care of:

Box 6, "The Canadian Nurse", 522 Medical Arts Bldg., Montreal 25, P.Q.

WANTED

General Duty nurses are required for a 90-bed Sanatorium. The salary is $95 per month; for night duty, $115; less tax, full maintenance. Experience unnecessary. Cost of railway ticket to St. Catharines will be refunded after 6 months' service. Apply, stating age, qualifications, and experience, to:

Supt. of Nurses, Niagara Peninsula Sanatorium, St. Catharines, Ont.

WANTED

A classroom **Instructress** is required for a 120-bed hospital. Apply, stating qualifications, experience, and salary expected, to:

The Superintendent, Stratford General Hospital, Stratford, Ont.

WANTED

General Duty nurses are required for a General Hospital in **Eastern Ontario.** 8-hour day. One extra day per month. Attractive salary and maintenance. Comfortable nurses' home. Vacation. **Dietitian** is also required. Salary: $130—full maintenance. Apply to:

Miss Martha Nephew, Supt., Cornwall General Hospital, Cornwall, Ont.

WANTED

A **Registered Nurse** is required for **General Duty** in a 30-bed hospital in a city of 9,000 in **Quebec Province.** Excellent recreation facilities. Pleasant living conditions. Some knowledge of French essential. Salary, $130 per month. Apply, outlining experience, in care of:

Box 5, "The Canadian Nurse", 522 Medical Arts Bldg., Montreal 25, P.Q.

WANTED

Applications are invited for the following positions in a 200-bed hospital: **Science Instructor, Clinical Supervisor, Pediatric Supervisor.** Apply, stating qualifications and salary expected, to:

Supt. of Nurses, Niagara Falls General Hospital, Niagara Falls, Ont.

WANTED

A qualified **Instructress** is required for the **Payzant Memorial Hospital.** The position is open **September 1, 1946.** Apply, stating qualifications, experience, and salary expected, to:

Supt., Payzant Memorial Hospital, Windsor, N.S.

WANTED

Verdun Protestant Hospital desires applications from nurses for **General Staff Duty.** State in first letter, date of graduation, experience, and when services would be available. Registered Nurses are also required for the position of **Assistant Night Supervisor** and as **Charge Nurses** for wards. Apply to:

Director of Nursing, Verdun Protestant Hospital, Box 6034, Verdun, P.Q.

WANTED

A **Registered Graduate nurse,** with Operating Room experience, is required for the **Soldiers' Memorial Hospital** in **Campbellton, New Brunswick.** Apply, stating qualifications, experience, and salary expected, to:

Miss H. C. Wilson, Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

WANTED

Vancouver General Hospital desires applications from Registered Nurses for **General Duty.** State in first letter date of graduation, experience, references, etc., and when services would be available.

Eight-hour day and six-day week. Salary: **$95** per month living out, plus **$19.92** Cost of Living Bonus, plus laundry. One and one-half days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. One month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to:

Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital,
Vancouver, B.C.

WANTED

Ontario Hospital, Kingston, requires Registered Nurses for **General Duty.** State date of graduation and references in first letter. 8-hour day and 6-day week. **Salary: $1300** per annum. Living out. Superannuation. 3 weeks' annual vacation with pay. Public holidays or equivalent time with pay. One and one-half days' sick leave per month, accumulative, with pay. Apply to:

Supt. of Nurses, Ontario Hospital, Kingston, Ont.

WANTED

Applications are invited for the position of **Science Instructor** at the **University of Alberta School of Nursing.** Duties to commence on or after **June 1, 1946.** Applicant to have University degree. Apply, stating qualifications, experience, etc., to:

Director, School of Nursing, University of Alberta, Edmonton, Alta.

WANTED

A **Graduate Nurse,** with Operating Room experience, is required for the **Barrie Memorial Hospital.** Apply to:

Superintendent, Barrie Memorial Hospital, Ormstown, P.Q.

WANTED

Applications are invited for the position of **Instructress of Nurses.** Apply to:

Supt., Kenora General Hospital, Kenora, Ont.

WANTED

Applications are invited for the positions of **Assistant Matron, Instructress,** and **Supervisor** in a 130-bed hospital. Apply, stating qualifications and salary expected, to:

Matron, King Edward VII Memorial Hospital, Bermuda

WANTED

Applications are invited for the following positions in a 170-bed hospital in the **Maritime Provinces,** with attractive salaries and maintenance: **Night Obstetrical Supervisor; Superintendent of Nurses; Instructress of Nurses; Supervisor,** experienced and qualified, for private floor, days; **Dietitian,** experienced and qualified. Apply in care of:

Box 4, "The Canadian Nurse", 522 Medical Arts Bldg., Montreal 25, P.Q.